HCASC
Harford County Ambulatory Surgical Center
1952-A Pulaski Highway
Edgewood, MD 20140
410-538-7000 Fax 410679-7825

Initial Patient Registration

Patient's Name: _____**Date:**_____

Address: _____

City/State: _____**Zip:** _____

Home Phone #: _____**Cell #:** _____

SS#: _____**Date of Birth:** _____

Gender (circle one): Male or Female Marital Status: _____

Employer: _____ **Full Time or Part Time**

Employer Address: _____

City/State: _____**Zip:** _____

Work Phone #: _____**Occupation:** _____

Primary Insurance: _____**ID#:** _____

Policy Holder's Name: _____ **SS#:** _____

Date of Birth: _____**Relationship to Patient:** _____

Group #: _____**Benefits Phone #:** _____

Claims Mailing Address: _____

City/State: _____**Zip:** _____

Policy Holder's Employer: _____

Address: _____

City/State: _____**Zip:** _____

Phone #: _____ **Full Time or Part Time**

Secondary Insurance: _____**ID#:**_____

Policy Holder's Name: _____**SS#:** _____

Date of Birth: _____**Relationship to Patient:** _____

Claims Mailing Address: _____

City/State: _____**Zip:** _____

Policy Holder's Employer: _____

Address: _____

City/State: _____**Zip:** _____

Phone #: _____ **Full Time or Part Time**

Work Compensation Claim? ÿ Yes ÿ No Date of Injury: _____**Claim#:**_____

Employer at the time of injury: _____

Employer Address: _____

City/State: _____**Zip:** _____

Work Compensation Insurance: _____

Claims Mailing Address: _____

City/State: _____**Zip:** _____

Adjuster's Name: _____**Phone:** _____

Personal Injury Claim: ÿAuto ÿOther: _____ **Date of Injury:** _____

PIP Insurance: _____

Claims Mailing Address: _____

City/State: _____**Zip:** _____

Adjuster's Name: _____**Phone:** _____

Attorney's Name: _____ **Phone:** _____

City/State/ZIP: _____

HCASC
Harford County Ambulatory Surgical Center

Accredited by

Accreditation Association
For Ambulatory Health Care, Inc.

MEDICARE CERTIFIED

MEDICATION RECONCILIATION

Patient Home Medication List recorded on Admission Date:_____
Allergies: List drug and Reaction

_____
_____
_____

Medications/Vitamins? Herbals: List drug, dose, and how often

Drug	Dose	How often	Last Taken

New/ Additional Medication after discharge

_____
_____
_____

The medication list above is the information you provided our staff, including and any changes we have made.

Patient Signature_____
Reviewed by Surgeon/RN_____Date _____

Please have this document available to provide a current medication list to your PCP
Revised 2/02/09

HCASC
Harford County Ambulatory Surgical Center

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Accreditation Association
For Ambulatory Health Care, Inc.

MEDICARE CERTIFIED

ADVANCE DIRECTIVES POLICY
HARFORD COUNTY AMBULATORY SURGERY CENTER

The purpose of this form is to provide information to all patients of their rights under Maryland state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

As specialists providing outpatient services in an ambulatory setting, Harford County Ambulatory Surgery Center does not directly address Advance Directives with patients scheduled for procedures at the Center. It is the policy of the Medical Director and staff to honor advance directives presented to them by their patients. However, should an untoward event happen to a patient while he or she is in our Center, it is also our policy to stabilize that patient and transport them to the hospital of their choice with a copy of the advance directive (if made available).

If you would like more information on the Maryland state law regarding Advance Directives, please ask the receptionist or you may go to the website:

http://www.oag.state.md.us/Healthpol/index.htm

I certify that I have read and understand the above information regarding Advance Directives and Harford County Ambulatory Surgery Center's policy regarding them.

(Please check all that pertain)

- ❑ I have formulated my Advance Directives. (Please bring a copy to the center with you.)
- ❑ I have not formulated my Advance Directives.
- ❑ I would like more information on how to formulate Advance Directives.

PATIENT'S SIGNATURE_____

DATE_____

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF YOUR PROCEDURE.

5/22/09

Professional Anesthesia Group, LLC

Authorization and Assignment of Benefits

I, _____, in consideration of the professional services rendered to me by Professional Anesthesia Group, LLC, voluntarily give consent for such treatment, and agree to the following:

Authorization for Release of Information

For the purpose of reimbursement of fees for professional services rendered by, Professional Anesthesia Group, LLC, I authorize the release of any necessary information to third party payors, insurance companies, attorneys, or other relevant parties to ensure payment for such services. Information provided by me regarding health care coverage is true and accurate to the best of my knowledge.

Assignment of Benefits

For services rendered, I hereby authorize my insurance company to assign and transfer any benefits due me to be paid directly to Professional Anesthesia Group, LLC. It is agreed that payment to Professional Anesthesia Group, LLC, pursuant to this authorization, by an insurance company, shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this agreement. If after 60 days from the date of services rendered and my insurance has not paid, I will be responsible for all balances due.

Financial Understanding and Guarantee of Payment

I understand that services rendered by Professional Anesthesia Group, LLC will require payment, and I acknowledge complete responsibility for such payment. I hereby obligate myself to pay the account of Professional Anesthesia Group, LLC in accordance with the regular rates and terms of such payment, and guarantee payment within three months from the date of service rendered. I further acknowledge responsibility for payment of all deductibles, co-payments, or other fees not covered by insurers or third party payors incurred by me as a result of services rendered. Should the account be referred to an attorney or licensed collection agency for collections, I shall be responsible for payment of all reasonable attorneys' fees and other collection expenses.

I hereby authorize any benefits due me to be paid directly to Professional Anesthesia Group, LLC in accordance with this assignment. I certify that I am the patient, a duly authorized general agent of the patient, or guardian of the patient, if a minor, and am authorized to execute this document and accept its terms.

_____ _____

Signature **Date**

_____ _____

Witness **Date**

Professional Anesthesia Group, LLC
1302 Rising Ridge Road, Suite 1
Mount Airy, Maryland 21771-5790
Phone # (301) 829-7683
Fax # (301) 829-7694

Notice of Privacy Practices

Effective Date: September 23, 2013

Note: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 104-191, **(The Health Insurance Portability and Accountability Act of 1996) (HIPAA),** mandates that we issue this new revised **Notice of Privacy Practices** to our patients. This privacy notice to our patients meets all current requirements, including the HIPAA/HITECH Omnibus final rule, as it relates to **Standards for Privacy of Individually Identifiable Health Information IIHI;** affecting our patients. You are urged to read this notice.

Every patient must receive our new Notice of Privacy Practices and execute a new Patient Authorization Form before this office may use your information for treatment, payment, or other health care operations (TPO). Your health information may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information. This notice will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

How We May Use and Disclose Your Protected Health Information

Our Notice of Privacy Practices informs you of our use and disclosure of your **Protected Health Information (PHI)**, defined as: "any information, whether oral or recorded in any medium, that is either created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past present or future payment for the provision of health care to an individual".

Our office will use or disclose your PHI for purposes of treatment, payment and other healthcare purposes as required to provide you the best quality healthcare services that we offer to the extent permitted by your Patient Authorization Form. It is our policy to control access to your PHI; and even in cases where access is permitted, we exercise a “minimum necessary information” restriction to that access. We define the minimum necessary information as the minimum necessary to accomplish the intent of the request.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of your physician’s practice.

Below are listed examples of the types of uses and disclosures of your PHI that our office is permitted to make.

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your health care and any related services. We may disclose your PHI to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

Different personnel in our organization may share information about you and disclose information to people who do not work for our organization in order to coordinate your care, such as calling in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside of our office and may require information about you that we may have. We will request your permission and authorization before sharing your PHI with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

Payment: We may use and disclose your PHI so that the treatment and services you received at our office may be billed to and payment may be collected from you, an insurance company, or a third party.

Health Care Operations: We may use or disclose, as needed, your PHI in order to make sure that you and our other patients receive quality care. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

Special Situations

In limited circumstances, The Privacy Standard permits, but does not require, covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities.

We may use or disclose your PHI for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety:** We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Required By Law:** We will disclose your PHI when required to do so by federal, state, or local law.

- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose PHI in response to a subpoena.

- **Law Enforcement:** We may release PHI if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.

- **Organ and Tissue Donation:** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

- **Military, Veterans, National Security and Intelligence:** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release PHI. We may also release information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation:** We may release PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks:** We may disclose your PHI for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- **Health Oversight Activities:** We may disclose your PHI to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- **Research:** We may use and disclose your PHI for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information that reveals your identity, or will be involved in your care at the office.

- **Information Not Personally Identifiable:** We may use or disclose PHI in a way that does not personally identify you or reveal who you are.

- **Coroners, Medical Examiners and Funeral Directors:** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- **Family and Friends:** We may disclose your PHI to your family members or friends if we obtain your permission and written authorization.

- **Specific State Laws:** There are specific state laws that required the disclosure of health care information related to Hepatitis C and AIDS. Where the state laws are more stringent than HIPAA Privacy Standard, the state laws will prevail.

Other Uses and Disclosures of Your Personal Health Information

We will not use or disclose your PHI for any purpose other than those identified in the previous sections without your specific, written Authorization. Examples of disclosures requiring your written authorization include disclosures to your partner, spouse, children, and your attorney.

On some occasions we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although we will institute a "chain of trust" contract and monitor our business associates' contracts with us, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way as to violate the Privacy Standard.

You, as our patient, may revoke your Patient Authorization Form at any time, **in writing**, and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI. To revoke either your Patient Authorization Form you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Patient Authorization Form. Any revocation will not apply to information already used or disclosed.

If you had a "personal representative" initiate as Authorization you may revoke that authorization at any time.

Uses and Disclosures that Require Us to Give You an Opportunity to Object

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Patient Rights Regarding Your PHI

You, the patient, have access to your health care information and have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy:** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to our office in order to inspect and/or copy records of your health information.

  You may request to view a copy of your health information. If you wish to inspect your health information, please submit your request in writing to our office. You have the right to request a copy of your health information in electronic form if we store your health information electronically.

- **Right to Amend:** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by our office.

  To request an amendment, complete and submit a Patient Request Form for Medical Record Information / Amendment to Medical Record to our office. We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny or partially deny your request if you as us to amend information that:

  - We did not create, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information that we keep;
  - You would not be permitted to inspect and copy; and/or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized

by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement. To obtain this list, you must submit your request in writing to our office. Your request should indicate the form/format you would like the list (electronic or paper).

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

  We are required to agree to your request if you pay for treatment, services, supplies and prescriptions in full, "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required by law to release this information. To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to our office.

- **Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you agreed to receive it electronically, you are still entitled to a paper copy. You may also find a copy of this Notice on our website.

Changes to This Notice

We reserve the right to change this notice and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will inform you of any significant changes to this Notice. This may be through a sign prominently posted at our locations, a notice posted on our website, or other means of communication.

Breach of Protected Health Information

We will inform you in a timely manner if there is a breach of your unsecured health information.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Although the law requires a signed and dated Notice of Privacy Practices, this office does not demand that you sign this agreement as a condition of receiving care. It is the law that your rights are communicated in this manner.

It is our practice to retain information about non-healthcare related requests for your health care information for a period of six years.

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your IIHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.
Please sign below and date the form indicating that you have received this Privacy Notice.

Thank you.

_____ Date: _____
Signature of Patient or Personal Representative

_____
Name printed

Professional Anesthesia Group, LLC
1302 Rising Ridge Road, Suite 1
Mount Airy, Maryland 21771
301-829-7683

HIPAA Privacy Standard
Consent Agreement / Patient Authorization Form

Patient's Full Name: _____

Street Address: _____

Social Security Number: _____ **Date of Birth:** _____

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not require that health care providers obtain a consent agreement as it relates to the use and disclosure of individually identifiable health information (IIHI), but many practices will continue to use the Consent Agreement for other purposes.

Though not necessary to have your consent to allow us to use or disclose your IIHI to others who will treat you or support in providing you quality health care services, it is important to have your consent to use or disclose your IIHI to health care plans to insure accurate and timely payments for the services rendered. The law requires that we inform you of our policy regarding the protection of your IIHI through our Notice of Privacy Practices. We may already have a consent agreement from you. Please refer to our Privacy Notice for a full explanation of how this office will protect your individually identifiable health information (IIHI).

In the event of a non-healthcare related request or a specific authorization request for personal health information, this office will request you complete a specific and separate Authorization Form for that particular request.

You, as our patient, may revoke your Patient Authorization Form at any time, **in writing**, and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI. To revoke either your Patient Authorization Form you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Patient Authorization Form. Any revocation will not apply to information already used or disclosed.

The following is a statement that allows us the necessary latitude to work within the new requirements.

I, _____, have been presented with a Notice of Privacy Practices explaining my rights regarding my individually identifiable health information (IIHI). I consent to the use and/or disclosure of my IIHI for purposes of treatment, payment or other health care operations (TPO). Other uses of my IIHI will require an authorization from me for the specific intention of disclosure.

Thank you for your continued confidence in our practice and for supporting our new requirements.

Patient Signature: _____ **Date:** _____

Note: In some states, there are additional consent agreements that must be included, e.g. special requirements to disclose specific information about patients with AIDS, Hepatitis C, and other specific diseases. Other consents, specific to the practice, may also be required. This statement refers only to the HIPAA Privacy Standard requirements. Refer to your specific state regulations to ensure you comply with those requirements.

Advanced Medical Management Multi-Specialty HealthCare Baltimore Work Rehab, LLC Harford Co. Ambulatory Surgery Center MRImages Pain Management MDDC, LLC MED, LLC	**Advanced Medical Management** We have an organizational and ethical responsibility to respect patient's rights, provide considerate and respectful care, affirm patient's rights to make decisions, assist and inform patients regarding their care, illness, marketing practices and admission and discharge practices. We adhere to a code of ethical behavior and policies and related to conflict of interest. The care a patient receives depends on the patient him/herself. In addition to patient rights, a patient has certain responsibilities as well. These responsibilities are presented to you, the patient, in the spirit of mutual trust and respect.

Patient Rights

And

Responsibilities

Our facilities and medical staff have adopted the following list of patients' rights and responsibilities.

The Patient Has The Right To:

- Receive service(s) without regard to age, race, color, sex, sexual orientation, marital status, national origin, culture, economic, educational or religious background or the source of payment for care.
- Be informed of the services available at the center.
- Be informed of the provisions for off-hour emergency coverage. Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and non-physicians who will participate in the care.
- Receive information from his/her physician about his/her illness, course of treatment and prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure that he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
- Participate actively in decisions regarding his/her medical treatment including the right to refuse treatment to the extent permitted by law and to be fully informed
- Have pain assessed and managed as part of the treatment process.
- Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely with consideration, respect and dignity. The patient has the right to be advised as to the reason for the presence of any individual involved in their care.
- Be provided information/explanation concerning how their health information is used and disclosed.
- Confidential treatment of all records and communications pertaining to his/her care. Written permission shall be obtained before medical records can be made available to anyone not directly concerned with your care.
- Reasonable responses to any reasonable requests he/she may make for service.
- Leave the center even against the advice of physicians.
- Be informed regarding patient billing practices, charges for services, eligibility for third-party reimbursements and when applicable, the available of reduced cost care.
- Receive a copy of his/her account statement upon request.
- Voice grievances and recommend changes in policies and services to the Center's staff, Privacy/Ethics Officer or the Maryland State Department of Health without fear of reprisal.
- Patient Responsibilities
- The patient must provide accurate and complete information concerning his/her present condition or complaints, past medical history and other matters about his/her health.
- The patient is responsible for following the treatment plan established by his/her physician, including the Instructions of nurses and other health professionals as they carry out the physician's orders.
- The patient is responsible for familiarizing him/herself with his/her insurance policy coverage and for assuring that the financial obligations toward his/her care and treatment are fulfilled as promptly as possible.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his/her personal property, other person's personal property in the facility and property of the facility.
- The patient is responsible for providing complete and accurate information including his/her full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer when it is necessary.
- The patient is responsible for keeping appointments, being on time for appointments and calling as soon as possible if he/she cannot keep his/her appointments.
- The patient is responsible for abiding by all the rules and regulations of this healthcare facility.

Grievance Policy

To make a suggestion to the organization and/or express grievances about any aspect of your experience with the Center, please contact the Compliance Officer at:
410-933-5678 Ext 6010
HCASC: 410-538-700 0 ext 113
Or write to:
Advanced Medical Management
9601 Pulaski Park Drive Suite 416
Baltimore, MD 21220
ATTN: Compliance
OR
MD Dept of Health and Mental Hygiene
ATTN: Marilyn Johnson
Spring Grove Hospital Center
Blane Bryant Bldg
55 Wade Avenue
Catonsville, MD 21228
1-800-492-6005
www.dhmh.maryland.gov/ohcq
OR Contact CMS directly at:
www.cms.hhs/gov/center/ombudsman.asp
There will be no retaliation for filing a complaint.

PRIVACY NOTICE

Advanced Medical Management
Multi-Specialty HealthCare
Baltimore Work Rehab, LLC
Harford Co. Ambulatory Surgery Center
MRImages
Pain Management
MDDC, LLC
MED, LLC

Understanding your health record and information:

By better understanding what is in your record, how your health information is used and your health information rights, we hope this information will assist you in making more informed decisions when authorizing disclosure to others.

Each time you visit your physician or other health care provider, a record of your visit or encounter is made. Typically, this record contains diagnosis, treatment and a plan for future care or treatment.

This information often referred to as your health or medical record, serves as:

- a basis for planning your care and treatment,
- a means of communicating amongst the many health professionals who contribute to your care,
- a legal documentation describing the care you received,
- a means by which you or a third-party payer can verify that services billed were actually provided,
- a source of information for public health officials charged with improving the health of the nation,
- a source of data for medical research,
- a source of data for the facility planning and marketing and,
- as a tool with which we can access and continually work to improve the care we render and the outcomes we achieve.

Your Health Information Rights:

Although your health record is the physical property of AMM, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to:

- obtain a paper copy of the notice of information practices
- restrict certain uses and disclosures of your information.
- Upon request, you can inspect and obtain a copy (paper or electronic) of your health record,
- obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations,
- revoke your authorization to use or disclose health information except to the extent that action has already been taken or for the use of treatment, payment or healthcare operations.
- restrict disclosures to a health plan concerning treatment for which the individual has paid out-of-pocket, in full.

Our Responsibilities:

AMM is required to maintain the privacy of your private health information (PHI), provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in our facility.

We will not use or disclose your health information without your authorization, except as describe in this notice.

Examples of Disclosures for Treatment, Payment and Health Operations:

We will use your health information for treatment:
For Example: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team, and record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We may also provide your physician or any subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you are discharged from this center.

We will use your health information for reminders and for follow-up phone calls.
For Example: A member of our nursing or physician staff may call you prior to or after your visit to obtain additional health information, give you instructions about your visit or inquire about your recovery. A member of the billing office may call prior to or after a visit to discuss your financial obligations.

We will use your health information for payment.
For Example: A bill may be sent to you or to a third-party payer. The information obtained identifies you as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.
For Example: Members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Working with Associated Businesses:
There are some services provided to our organization through associated businesses. Examples include physician services radiology, laboratory, pathology and a transcription services we use when compiling your health record. When these services are contracted, we may disclose your information to them so they can perform their function effectively. In order to protect your health information, however, we require these businesses to sign a business associate agreement, in which they agree to protect the security and privacy of your private health information. This law effects the business associate as well as any subcontractor the business associate may contract with.

Directory:
Unless you notify us that you object, we will use your name, Location in the facility and general condition for directory purposes. This information may be provided to people who ask for you by name.

Marketing:
Authorization is required for uses and disclosures of PHI for marketing and/or fundraising purposes and disclosures that constitute a sale of PHI.

Advanced Medical Management
9601 Pulaski Park Drive Suite 416
Baltimore, MD 21220

Notification:
We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, your location and general condition.

Communication with Family:
Health professions, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related your care.

Communications & Effective Treatment:
This office reserves the right to contact you with appointment reminders or information about treatment alternatives and other health-related benefits that may be appropriate to you.

Food & Drug Administration (FDA):
We may disclose to the FDA, health information relative to adverse events with respect to food, supplements, products, Product defects or post -marking surveillance information to enable product recalls, repairs or replacements.

Workers Compensation:
We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health:
As required by law, we may disclose your health information to public or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution:
Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health and the health and safety of other individuals.

Law Enforcement:
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, in the event that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

HITECH Act/Breach Notification:
Any impermissible use or disclosure of PHI is presumed to be a breach, with a subsequent requirement to provide a breach notification, unless the covered entity or business associate demonstrates that there is low probability that the PHI has been compromised. The covered entity must maintain documentation sufficient to meet the burden of proof that the disclosure did not constitute a breach.

For More Information or to report a problem:
Please contact the Compliance Officer at: 410-933-5678 ext. 6010. If you believe that your privacy rights have been violated you may file a complaint with the compliance officer at the address listed on this page, or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

MULTI-SPECIALTY HEALTH CARE

901 Eastern Boulevard ♦ Baltimore, MD 21221 ♦ 410-682-5500 ♦ Fax 410-686-1178

Date:_____

Dear_____,

We have you scheduled for surgery with _____ on _____.
Before you have surgery**, you must complete some tests necessary before surgery.** The tests are in 2 parts.

Part 1- Please report to the office indicated below for your pre-op testing, which will include blood work and possibly an EKG and chest x-rays.
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Part 2- Please report back to the same location on the day/time indicated below for your pre-op exam and for the doctor to review your blood work and other test results. The doctor will then let you know if you have been cleared for surgery.

If you are unable to make these appointments, please call our office ASAP to reschedule them.

Your pre-op testing has been scheduled for:

Part 1- _____ **Part 2-**_____

Medical Assistant: _____ Doctor:_____

LOCATION

_____Multi-Specialty Health Care-**Overlea**
660 Belair Road
Baltimore, MD 21206
Phone: 410-444-2000

_____Multi-Specialty Health Care-**Essex**
901 Eastern Blvd
Suite 200
Baltimore, MD 21221
Phone: 410-682-5500

DIRECTIONS TO:
HARFORD COUNTY AMBULATORY SURGERY CENTER

FROM BALTIMORE:

Take 695 to I95 north to exit 74 (Joppatowne/Fallston). Make a right off the exit onto Rt. 152 (Mountain Rd). Go to the second stoplight and make a left which will be Rt. 40 (Pulaski Hwy,). Go through the next three stoplights, (Paul Martin Drive will be the third light), after passing through the third light there will be a break in the road in which you will want to make a u-turn. We are located on the right next to Wendy's.

OR

From East Baltimore you can come out Rt. 40 (Pulaski Hwy). Go past Baltimore County and through Joppatowne. A little further out will be Rt. 152 (Mountain Rd./Magnolia Rd.). After passing through the light at Mountain Rd. go through the next three lights (Paul Martin Drive will be the third light), after the passing through the third light there will be a break in the road in which you will want to make a u-turn. We are located on the right next to Wendy's.

FROM NORTH:

Take I95 South to exit 74 (Joppatowne/Fallston). Make a left off of the exit. Go to the third stop light and make a left, which will be Rt. 40 (Pulaski Hwy.). Go through the next three stoplights, (Paul Martin Drive will be the third light), after passing through the third light there will be a break in the road in which you will want to make a u-turn. We are located on the right next to Wendy's.

Pull onto the parking lot and enter the building through the door with the blue awning.

If you have any questions, please feel free to call the Surgery Center at 410-538-7000. We will be glad to help you.