HCASC
Harford County Ambulatory Surgery Center
1952-A Pulaski Highway • Edgewood, MD 21040
410-538-7000 • Fax: 410-679-7825

INITIAL PATIENT REGISTRATON

PATIENT'S NAME: _____ DATE: _____
Address: _____
City/State : _____ Zip: _____
Home Phone #: _____ Cell #: _____
SS #: _____ Date of Birth: _____
Male or Female: _____ Marital Status: _____

EMPLOYER: _____ Full or Part Time: _____
Employer Address: _____
City/State: _____ Zip: _____
Work Phone #: _____

PRIMARY INS.: _____ 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 or Part Time: _____

SECONDARY INS.: _____ 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 or Part Time: _____

PLEASE TURN OVER AND COMPLETE REVERSE SIDE IF WORKER'S COMPENSATION CLAIM OR PERSONAL INJURY CLAIM PERTAINS TO YOU

Work Compensation Claim: ☐ Yes ☐ No Date of Injury: _____

Full or Part Time: _____

Claim #: _____

EMPLOYER: _____

Employer Address: _____

City/State: _____ Zip: _____

Phone # _____

Work Compensation Ins. Co.: _____

Claims Mailing Address: _____

City/State: _____ Zip: _____

Adjuster Name: _____ Phone #: _____

Attorney Name: _____

Attorney Address: _____

City/State: _____ Zip: _____

Attorney Phone #: _____

Personal Injury Claim AUTO/OTHER DATE OF ACCIDENT _____

PIP Ins. Carrier: _____

Claims Address: _____

City/State: _____ Zip: _____

Adjuster Name: _____ Phone #: _____

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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

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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.

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.
1311 S. Main Street # 204
Mt. Airy, MD 21771
Phone # (301) 829-7683

Privacy Notice

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 **Privacy Notice** to our patients. This notice to our patients meets all current requirements as it relates to **Standards for Privacy of Individually Identifiable Health Information IIHI);** affecting our patients. You are urged to read this notice.

As part of the Privacy Standard, implemented on April 14, 2001, you are required to provide this office with a new, signed and dated, **Consent Agreement**. Every patient must receive our new Privacy Notice and execute a new Consent Agreement before this office may use your information for treatment, payment, or other health care operations (TPO).

Our Privacy Notice 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 Consent Agreement or in such specific situations, by your signed and dated Authorization. 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.

An Authorization differs from a Consent Agreement in that it is very specific with regard to the information allowed to be disclosed or used, the individual or entity to which the information may be disclosed to, the intent for which it may be disclosed, and the date that it was initiated which may include the duration of the authorization. This is a form, separate from the Consent Agreement, and usually used only for one specific request for information. In the event of a non-healthcare related request for personal health information this office will request you to complete an Authorization Form.

You, as our patient, may revoke any Consent Agreement or Authorization at any time 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 the Consent Agreement or the Authorization you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Authorization or Consent Agreement. 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.

You, the patient have access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information. The physician or principal will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes to the information. If the physician or professional agrees with the request to amend the information, we are bound by law to abide by the changes.

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.

These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or to assist in determining the cause of death; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. 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.

All of these disclosures could occur previously under former laws and regulations however, The Privacy Standard establishes new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use our professional judgments to decide whether to disclose any information, reflecting our own policies and ethical principals.

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.

Although the law requires a signed and dated Privacy Notice, 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

Figure 1

Professional Anesthesia Group, LLC.
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Mt. Airy, MD 21771
Phone # (301) 829-7683

Consent Agreement

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 Privacy Notice. 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).

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

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

I, _____, have been presented with a Privacy Notice 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.

Patient: _____ Date: _____