

Alpine Plastic and Reconstructive Surgery

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In All Fields)

Patient's Name _____ Gender: M F
Last First Middle

Address _____
Street & Apt # City State Zip

Age _____ DOB _____ SS# _____ / Single Married (to _____)

Phone: Home _____ Leave Msg? Y N Cell _____ Leave Msg? Y N

Email _____

Preferred method of receiving follow-up information/documentation (please circle one): Mail Email

Emergency Contact _____ Relationship to Patient _____
Contact number(s) _____

Referral Information (please circle one) Phonebook Website Billboards Radio
Other: Family/Friend _____ Physician _____ ER _____
(List name, relationship) (List name of physician) (List Hospital/ER)

**Are you here due to an injury/accident? Yes No (See Accident Questionnaire)

Release of Information

_____ Yes, Alpine Plastic Surgery and/or Alpine Surgical Center Staff may speak to any of my family/friends who may inquire about my care.
_____ Alpine Plastic Surgery and/or Alpine Surgical Center Staff may speak to only the specific family/friends listed below.

Name(s) and Phone Number(s) _____

Patient's Employer _____ Occupation _____
Work Phone _____ Ext _____ May we call you at work? Yes No
Address _____
Street & Suite # City State Zip
Status: (please circle one) Full Time Part Time Retired Unemployed

We require insurance information on all patients regardless of nature of office visit

Primary Insurance

Person Responsible for Account _____
Last First Middle
Relation to Patient _____ DOB _____ SSN _____
Address (if different from patient) _____
Phone _____ Employer _____
Insurance Co _____ Co-Pay Amount _____
ID Number _____ Group Number _____ Referral: Yes/No

Additional Insurance Yes/No

Account Holder _____ Relation to Patient _____
Phone _____ DOB _____ SSN _____
Address (if different from patient) _____
Employer _____
Insurance Co _____ Co-Pay Amount _____
ID Number _____ Group Number _____ Referral: Yes/No

Release of Medical Information, Assignment of Benefits & Accounts

I hereby authorize all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to be paid directly to "Alpine Plastic and Reconstructive Surgery" for their services. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by insurance. If collection proceedings are required, I agree to pay all legal fees and cost of collection, with or without suite, including attorney fees, collection fees and court costs. I hereby authorize said assignee to release all information to secure the payment.

Patient Signature

Date

If Minor, Responsible Party Signature

Date

Alpine Plastic and Reconstructive Surgery

Health Information as of _____ (enter today's date)
 (Please Print Legibly & Fill In All Fields)

| | | | |
|-------------------------------|-----|----------------|--------------|
| Patient: | | | |
| DOB | Age | Marital Status | Weight lbs |
| What is your chief complaint? | | | Height ft in |

DO YOU NOW OR HAVE YOU EVER HAD..... (You must circle an answer for each individual item)

| | | | | | |
|---|-----|----|--|-----|----|
| Diabetes | Yes | No | Do you wear contact lenses or glasses? | Yes | No |
| Hypoglycemia (Low Blood Sugar) | Yes | No | Are you receiving treatment for glaucoma? | Yes | No |
| Thyroid Problems | Yes | No | Have you been coughing up or spitting blood? | Yes | No |
| Heart Problems (rheumatic fever, Murmur, Chest Pain, Heart Attack, Irregular Heartbeat, Angina, Ankle Swelling, Valve Replacement etc.) | Yes | No | Do you have any of the following? (Please Circle) False Teeth Loose Teeth Chipped Teeth Caps/Crowns Braces Retainers Bridges Body Piercing | | |
| Blood Clots - Factor 5, Transfusion Problems, Bleeding Tendency) Or any of your Family Members? | Yes | No | Do you have any special communication needs? Hearing Language Speech Vision | | |
| High Blood Pressure | Yes | No | Do you have any physical limitations? | | |
| Stroke (Weakness/Numbness one side, Difficulty Speaking etc.) | Yes | No | Have you ever had Tuberculosis (TB)? | Yes | No |
| Seizures (Epilepsy, Convulsions, Blackouts etc.) | Yes | No | Have you been living with anyone in the past 2 yrs with TB? | Yes | No |
| Neurological Problems (Loss of Sensation, Numbness, Tingling etc.) | Yes | No | Do you have an advanced directive? | Yes | No |
| Severe Headaches | Yes | No | Are you able to provide us with a copy? | Yes | No |
| Lung Problems (Asthma, Pneumonia, Shortness of Breath, Emphysema, Abnormal Chest x-ray etc.) | Yes | No | Have you ever had a bad reaction to Anesthesia? | Yes | No |
| Sleep Apnea | Yes | No | Has a blood relative had a bad reaction to Anesthesia? | Yes | No |
| Liver Problems (Jaundice, Hepatitis, etc.) | Yes | No | Have you had a persistent cough, fever, night sweats or loss of appetite for more than 2 weeks? | Yes | No |
| Kidney, Bladder or Prostate Problems (Infections, etc.) | Yes | No | Have you used cortisone, prednisone or steroids within the past year? | Yes | No |
| Stomach Problems (Ulcer, Hiatus Hernia, Reflux, Heartburn, etc.) | Yes | No | If the patient is a child: | | |
| Bowel Problems (Irritable Bowel, Diverticulitis, etc.) | Yes | No | Was the child premature? | Yes | No |
| Back Trouble (Strain, Disc Problems, Numbness/Tingling of Hands or Feet, etc.) | Yes | No | Any birth defects or developmental problems? | Yes | No |
| Difficulty Opening Mouth (TMJ, etc.) | Yes | No | Any immunization problems or delays? | Yes | No |
| Broken Bones of Head, Neck or Spine (Please List) | Yes | No | Any history of breath holding, berating problems or croup? | Yes | No |
| Restrictions in Movement (Please List) | Yes | No | | | |
| Arthritis | Yes | No | | | |
| Muscle Disorders (MD, Myasthenia Gravis, etc.) | Yes | No | | | |
| Cancer | Yes | No | | | |
| Mental Health / Phobias (Anxiety, Depression, Psychosis, etc.) | Yes | No | | | |
| Mental Disability (Confusion, Memory Loss, Downs Syndrome, etc.) | Yes | No | | | |
| Skin Problems (Eczema, Fragile, etc.) | Yes | No | | | |
| Eye Problems (Dry eyes, Excessive Tearing) | Yes | No | | | |
| Pain in the Past Several Weeks | Yes | No | | | |
| Pain that Limits Daily Activities | Yes | No | | | |
| History of Falls | Yes | No | | | |
| Illness, Cold, Cough or Fever within the last week? | Yes | No | | | |
| Recent Exposure to any Communicable Disease? | Yes | No | | | |
| Other Medical Problems (Please List) | | | | | |
| Do you take Coumadin, Aspirin or any other Blood thinner? (Please List) | | | | | |

For Office Staff Use Only

Alpine Plastic and Reconstructive Surgery

Please list all present medications, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. Include over-the-counter medications.

Do you have any allergies (Medications, Foods, Latex, Tape, Other?) Yes No Explain _____

Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

Yes No Yes If so, how much? _____ Caffeine No If so, how much? _____

Do you smoke? Yes No If so, how much? _____ For how long? _____ Date Quit _____

Do No Yes you use street drugs If so, what kind? _____ For how long? _____

Are you pregnant? Yes No When was your last menstrual period? _____ Hyster. Date _____

How many pregnancies? _____ Births? _____ Breast Fed? Yes No How long? _____

Are you planning on getting pregnant? _____ How Soon? _____

Do you exercise? _____ How often? _____

When was your last physical exam? _____ By whom? _____

Who is your personal physician, if any? _____

Please list all physicians presently caring for you.

Is there anything else you think the doctor should know? _____

Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons: _____

SURGICAL OPERATIONS (include where, when and why for each surgery): _____

Describe all serious accidents, severe injuries, head injuries, fracture or broken bones (include where, when and how for each injury):

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Patient Name: _____

Signature: _____ Date: _____

Alpine Plastic and Reconstructive Surgery

Accident Questionnaire

(If Applicable)

Patient Name _____ DOB _____

Date of Injury _____

Where did injury occur? _____

How did injury occur? _____

If Work Related:

Name of Employer _____

Name of Supervisor _____

Phone Number _____

Injury was reported to? _____

WC Carrier & Claim number _____

If Other Accident, please circle which one applies to you:

Auto

Home Owners

Name of Insurance Co. _____

Policy Number _____

Name of Home Owner _____

Address, Phone Number # _____

Has it Been Reported? _____

If YES, Claim Number _____

By signing below, I am agreeing that the above information accurate and correct to the best of my knowledge.

Signature _____ Date _____

Alpine Plastic and Reconstructive Surgery

PATIENT CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

The undersigned, as either (a) the patient receiving care by Alpine Plastic & Reconstructive Surgery, P.C. or its physicians or medical staff (collectively "Alpine") or by Alpine Surgical Center, LLC or its nursing and other personnel (the "Facility") or (b) the legally authorized representative or responsible financial guarantor of the Patient, hereby makes the following consents, understandings, and agreements on my own behalf and on behalf of the Patient, in partial consideration of health care services to be provided to the Patient by Alpine, by or in the Facility or by their respective medical staffs:

Consent for Services: I hereby give consent to Alpine and the Facility, and their respective medical staff, contractors, physicians, and employees to provide health care services to the Patient and to administer physician orders and related medical care, tests, studies and/or services for the benefit of the Patient for this visit and any subsequent visits. Patient will inform Alpine and its medical staff of all medications being taken and will discontinue use of medications which are not ordered or approved by Alpine or its medical staff as reflected in Alpine's medical records for Patient. I understand that there is a risk of substantial and serious harm involved in such health care services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises or guarantees of any particular outcome or successful result have been made.

Cosmetic Surgery: I understand that certain medical services and procedures, including but not limited to elective cosmetic surgery procedures, are generally not covered or otherwise entitled to benefits under individual or group welfare benefit plans, including insurance plans or products, that I may have or be entitled to benefits under ("Uninsured Procedures").

Fees: Due to the wide variety of patient medical conditions and the nature of the cosmetic, surgical and reconstructive services Alpine physicians treat, Alpine and Facility are generally unable to estimate in advance the fees or charges which might be incurred for your treatment. The fees of Alpine and Facility are based upon its reasonable and customary fee schedule. I understand and agree that, if and to the extent Alpine has quoted any fee reduction or other discount for multiple surgical procedures or other health care services, any such fee reduction or discount is intended to, and shall, apply solely to Uninsured Procedures. Solely with respect to Uninsured Procedures, the fee quoted by Alpine includes (i) the physician fees of Alpine (including usual and customary post-operative visits), (ii) the fee payable by Patient to the Facility and (iii) the fee payable by Patient to Anesthesia. In all other cases, Patient is directly responsible for payment of the Facility fee to Facility and the Anesthesia fee to Anesthesia. Fees do not include, and Patient is solely responsible for, fees or charges of any other health care providers or facilities which provide items or services to Patient (for instance, if Patient is transferred in emergent circumstances).

Payment and Scheduling Policies: All co-payments, deductibles, co-insurance, and/or charges for non-covered services are due and payable on or before the time of service. I understand that it is my responsibility to know the provisions of my insurance policies, what services are covered and which providers, facilities or locations are preferred or within network. A list of insurances accepted by Alpine and the Facility is available upon request.

For cosmetic surgery/Uninsured Procedure patients only: A \$50.00 consultation fee is due and payable at the first appointment. This fee will be credited against the fees associated with any cosmetic surgery procedure performed by Alpine. Any fees quoted are valid for one (1) year from the date of the initial consultation.

For self-pay patients: A \$50.00 fee is due and payable at the first appointment. Patient and the undersigned, if other than the Patient, remain responsible for any remaining balance for items or services rendered as provided below.

For all patients: When scheduling a surgery date you are required to set up a pre-operative appointment. Your pre-operative appointment should be scheduled at least one week prior to your surgery date. If you do not show up for your pre-operative appointment you will be taken off of the surgery schedule.

- Payment in full or insurance company pre-authorization is required at the time of your pre-operative appointment to secure your surgery date and time. Methods of payment accepted: Cash, Money Order, Cashiers Check, Travelers check, Visa, or Master Card. No personal checks will be accepted. Once you have secured a surgery date and time, a \$500 cancellation fee will be applied. This fee is non-refundable. If you are scheduled for a no charge procedure or touch up procedure and cancel the procedure within one week of your surgery date a \$500 rescheduling fee will be charged.

Relationship of Providers: I understand that (a) Alpine provides professional medical services (including but not limited to plastic and reconstructive surgery services) of physicians licensed under the Utah Medical Practice Act, (b) the Facility provides outpatient surgery center facility services (e.g., nursing services, services of technical personnel and other services related to the surgical procedure, drugs, biological, surgical dressings and administrative, recordkeeping and housekeeping items and services), and (c) anesthesia services are provided by an independent anesthesiologist and/or certified registered nurse anesthetists under the supervision of the independent anesthesiologist (collectively, "Anesthesia"). Alpine, the Facility and Anesthesia are legally separate and independent providers.

Release of Information: Alpine and the Facility are each required by law to make and keep records of the Patient's medical treatment. Both Alpine and the Facility safeguard those records and use and disclose such records and the information they contain only in accordance with applicable state and federal privacy laws. Such uses and disclosures are described in detail in Alpine's and the Facility's respective Notice of Privacy Practices, which may be amended from time to time. I understand that either the Patient or I may ask to see a copy of the current notice at any time. [Confirm/review Notice of Privacy Practices]

Alpine Plastic and Reconstructive Surgery

Insurance/Assignment of Benefits: Any and all benefits from insurance companies and other third party payors that are payable to the Patient or on behalf of the Patient for health care services and related payments for services rendered or provided to the Patient are hereby transferred and assigned to Alpine and/or the Facility, as the case may be, for the exclusive purpose of paying for charges associated with the health care services provided to the Patient by Alpine or the Facility. I understand and intend that all insurance companies and other third party payors will pay benefits directly to Alpine and/or the Facility in payment of their charges and the charges of any other health care providers for whom either Alpine or the Facility is authorized to bill in connection with health care services provided to the Patient.

- I understand that I am responsible for complying with the pre-authorization and other requirements of any insurance policies which provide, or may provide, coverage for services rendered or provided by Alpine and/or the Facility, and that I am responsible for any balances remaining after third party payments, if any, are received. Alpine and/or the Facility will file insurance claims with insurance companies and other third party payors for any procedures which are likely to be covered under Patient's insurance, so long as I furnish proof of coverage and related insurance benefits information at or prior to my pre-operative appointment.

Financial Responsibility: Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all health care services rendered or supplies provided to the Patient by Alpine and/or the Facility including but not limited to any amounts not paid by any insurance company or other third party payor (excluding any contract discounts agreed upon in writing by Alpine and/or the Facility with the applicable third party payor). Patient and the undersigned, if other than the Patient, remain responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third party payor. I understand and agree that any amounts not paid within 30 days of the date of the invoice or billing statement shall accrue interest at the rate of 1 ½% per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed with a collection agency or attorney for collection, Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay costs and reasonable attorneys' fees in connection with the collection process. A service charge may be collected in connection with any check or other instrument tendered by the Patient or the undersigned but returned unpaid.

Patient's Certification: I authorize any holder of medical or other information about me to release to the Social Security Administration, other intermediaries or carriers, the State, or any insurance company or other payor any information needed to process a claim for this or any related service. I request that payment of authorized charges be made on my behalf directly to Alpine and/or the Facility for its charges and for any charges of physicians or other providers for whom Alpine and/or the Facility is authorized to bill in connection with its service.

Certain Financial Relationships: Dr. Barnett and Dr. Berry (an independent contractor anesthesiologist) are owners of the Facility and therefore have a "financial relationship" with Facility for purposes of Utah Code § 58-67-801. Alpine patients may choose any surgery facility for the purpose of having the medical services and procedures performed. Alpine physicians are only able to perform surgical procedures in hospitals or other health care facilities in which they have medical staff privileges and which are otherwise medically appropriate for the services or procedures.

Entire Agreement: Patient and the undersigned, if other than the Patient, each jointly and severally agree that, except for the most recent written fee or price quote by Alpine to Patient for uninsured cosmetic surgery procedures (which price quote is incorporated herein by specific reference), this Agreement is a final and complete expression of the agreement between the parties and no other terms or conditions, regardless of whether written or verbal, are or shall be a part of this Agreement.

The undersigned signs this document either as the Patient, as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient, or responsible financial guarantor of the Patient (and as an accommodation to Patient and for other legally adequate consideration), I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing below. I understand that I am entitled to request and obtain a copy of this document.

Signed: _____
(Patient)

Date: _____

Patient Name: _____
(Print name)

Alpine Plastic and Reconstructive Surgery

Patient Rights

Alpine Plastic & Reconstructive Surgery and medical staff have adopted the following list of patient rights. This list shall include, but is not limited to, the patients' right to:

- Exercise these rights without regard to sex, culture, economic, education, religion, or source of payment for his/her case.
- Expect care that respects his/her psychosocial, spiritual, personal and cultural values and allows him/her to express these values and practices that do not harm others or interfere with medical therapy.
- Be treated with consideration, respect, and full recognition of personal dignity and individuality including privacy in treatment and care of personal needs.
- Receive as much information regarding proposed treatment or procedure, as he/she may need in order to give informed consent or to refuse this course of treatment.
- Be involved in resolving conflicts about care decisions to the extent permitted by law; this includes the right to refuse treatment, and/or leave the facility even against the advise of his/her physician.
- Be informed of services available in the facility and of any expected charges for which the patient may be liable.
- Be fully informed of your rights and all facility rules and policies that pertain to his/her conduct while a patient.
- Be informed of any investigational, research, or educational activities related to care and can refuse to participate in any such activities without that refusal compromising usual care.
- Confidential treatment of personal and medical records and to approve or refuse release to any individual outside the facility, or as required by law or third party payment contract.
- Effective communication and physical access to the facility that considers hearing, speech, visual, and physical impairments.
- To complain about care and to have complaints reviewed, and when possible, resolved see Risk Manager.
- Receive written information regarding current licensure, relevant education, training and experience of the surgeon who will perform the procedure and the practitioner administering and monitoring anesthesia.

Patient Responsibility

The care a patient receives depends partially on the patients themselves. Therefore, in addition to patient rights, a patient has certain responsibilities as well. These responsibilities shall be presented to the patient in the spirit of mutual trust and respect.

Providing information. The patient is responsible for providing, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications (including non-prescribed and herbal), unexpected changes in the patient's condition, advance directives, and other matters of care.

Asking questions. Patients are responsible for asking questions when they did not understand what they have been told or what they are expected to do.

Following instructions. The patient and family are responsible for following the pre-operative and post-discharge care plan. They should express any concerns they have about their ability to follow and comply with the proposed care plan or course of treatment, including anesthesia or operative requirements. Every effort is made to adapt the plan to patient's specific needs and limitations.

Accepting consequences. The patient and family are responsible for the outcomes if they do not follow the care plan.

Following policies and procedures. The patient and family are responsible for following the practice's policies and procedures concerning patient care and conduct.

Showing respect and consideration. Patients and families are responsible for being considerate of the practice's staff and property.

Meeting financial commitments. The patient and family are responsible for promptly meeting any financial obligation agreed to with the practice.

Keeping appointments. The patient is responsible for keeping appointments and for notifying Alpine Plastic and Reconstructive Surgery when he or she is unable to do so.

Alpine Plastic and Reconstructive Surgery

Understanding Your Health Record /Information

Each time you visit Alpine Plastic & Reconstructive Surgery a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your medical chart / record or your personal health information (PHI), serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess 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 Alpine Plastic & Reconstructive Surgery the information belongs to you. You have the right to:

- *Right to Receive a Copy of this Notice:* Upon request, you have the right to receive a paper copy of this Notice. You may pick up a copy of the Notice at the reception desk, or have it sent by postal mail.
- *Right to Receive Further Information and Complain:* You have the right to contact our Privacy Officer and obtain additional information about our privacy practices, your privacy rights, and the uses and disclosures of your protected health information. If you disagree about a decision, we made about your protected health information, or if you believe that your privacy rights have been violated, you may make a formal complaint addressed to our Privacy Officer @ 387-3900, or to the Secretary of the Office of the Department of Health and Human Services 1961 South Street, Room 1185 FOB, Denver, CO 80294-3538. Voice Phone (303) 844-2024 FAX (303) 844-2025
- *Right to Inspect and Copy Your Health Information:* Upon Request, you have the right to access and obtain a copy of your health information maintained by us. Our Privacy Officer @ 387-3914, can provide you with the form to request inspection of your health information.
- *Right to Request an Amendment to Your Health Information.* You have the right to request that we amend your health information maintained in your medical record. We will comply with your request in the event that we determine the information that would be amended is false, inaccurate or misleading. The Privacy Officer @387-3900 can provide information on how to request an amendment to your health information.
- *Right to Request Additional Restrictions on Uses and Disclosures of Your Health Information:* You have the right to request that we place additional restrictions on how we use or disclose your personal health information. While we will consider any request for additional restrictions, we are not required to agree to your request. Our Privacy Officer can provide you with a form to request restrictions on the use or disclosure of your health information if other than outlined in this notice
- *Right to Request an Accounting of Disclosures:* You have a right to request an accounting of the disclosures made by us of your personal health information (other than for treatment, payment, or health care operations.) For each disclosure, the accounting will include the date the information was disclosed, to whom, the address of the person or entity that received the disclosure (if known), and a brief statement of the reason for the disclosure. Our Privacy Officer can provide you with a form to request an accounting of disclosure and use of your health information
- *Right to Request Confidentiality in Certain Communications:* You have the right to request your health information be received by alternative means of communication or at alternative locations. We will accommodate any such reasonable written request made on your behalf. The Privacy Officer can provide you with a form to request an alternative means of communicating your health information.
- *Right to File a Complaint.* If you believe your privacy rights have been violated, you also have the right to file a written complaint with Office of Civil Rights of the United States Department of Health and Human Services. The Privacy Officer can provide you with information on how to file your complaint. Under no circumstances will we retaliate against you for filing a complaint

Our Responsibilities

This practice is required to:

- Maintain the privacy of your health information
- 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.
- We will not use or disclose your health information without your authorization, except as described in this notice.
-

For More Information or to Report a Problem

If you have questions and would like additional information, contact our Privacy Officer @ (801) 387-3900 or by mail.

Alpine Plastic & Reconstructive Surgery
Attn: Privacy Officer
4403 Harrison Blvd. #3680
So. Ogden, UT 84403

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer or with the Secretary of Health and Human Services.

Dept. of Health and Human Services
1961 South Street, Room 1185 FOB
Denver, CO 80294-3538
Voice Phone (303) 844-2024 FAX (303) 844-2025

Alpine Plastic and Reconstructive Surgery

Examples of Disclosures for Treatment, Payment and Health Operations

As a condition of obtaining treatment, you will be asked to sign a written consent form authorizing (*the practice*) to use your protected health information for our treatment, payment and healthcare operations. Upon obtaining consent, we may use and disclose your protected health information in the following ways:

For example:

- **Treatment:** Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine 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. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. This information will be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
- **Payment:** A bill may be sent to a third party. The information that may be included in order to process the claim may include information from your PHI that may identify you as well as your diagnosis, medications prescribed, and supplies used.
- **Health Care Operations:** Members of our organization may use your PHI to assess the care and outcomes in your case and in others like it. For uses and disclosures of your protected health information not involving treatment, payment and healthcare operations: We are required to obtain your written authorization prior to using or disclosing your protected health information (unless we are otherwise required or permitted by law to use or disclose your information as set forth below). You have the right to revoke any authorization previously granted. If you have questions about written authorizations, or how to revoke such authorizations, please contact our Privacy Officer @ 387-3900. We will also provide your subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from in addition, we may use or disclose your protected health information without your consent or authorization, in the following circumstances:
 - **Use and Disclosure without Consent:** We may use and disclose your protected health information for treatment, payment and healthcare operations without your consent or authorization for emergency treatment; when we are required by law to treat you, attempt to obtain your consent but cannot; and when we are unable to obtain your consent due to substantial communication barriers. In such situations, we will attempt to obtain your consent as soon as practicable.
 - **Uses and Disclosures Required by Law:** We may use or disclose your protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of the law.
 - **Business Associates:** There are some services provided within our (clinic) through contacts with business associates. For example, a pharmacy or laboratory. When these services are contracted we may disclose your health information to our business associates so that they can perform their job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require any of our business associates to appropriately safeguard your information.
 - **Notification of Family or Close Friends:** 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, provided you have the opportunity to agree or object to the disclosure. If you are unable to agree or object, we may disclose this information as necessary if we determine that it is in your best interests based upon our professional judgment. In all such cases, we will only disclose the protected health information that is directly relevant to that person's involvement with your healthcare.
 - **Research:** We may disclose information to researchers when an institutional review board, which has reviewed the research proposal and established protocols to ensure the privacy of your health information, has approved their research
 - **Coroners:** We may disclose your protected health information to a coroner or medical examiner in accordance with applicable laws.
 - **Funeral Directors:** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
 - **Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
 - **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 health or legal authorities authorized by law to collect or receive such information for controlling disease, injury or disability. We may also disclose your health information to a public health authority authorized by law to receive reports of child abuse or neglect, or domestic violence.
 - **Health Oversight Activities:** We may make disclosures of your protected health information to a health oversight agency charged with overseeing the healthcare industry in accordance with applicable law.
 - **Judicial and Administrative Proceedings:** We may disclose your protected health information in any judicial or administrative proceeding in response to orders, subpoenas and other valid legal process.

Alpine Plastic and Reconstructive Surgery

Notice of Information Practices / Patient Rights and Responsibilities
Acknowledgement of Receipt

I have received/read and understand the Notice of Privacy Practices and the Patient Rights & Responsibilities of Alpine Plastic & Reconstructive Surgery and Alpine Surgical Center, LLC. I understand that by signing this document I am acknowledging that I have received these forms and that I understand that additional copies are available to me per my request.

Signature of Patient or Legal Representative

Date