PSA Surgery Center of Killeen
A Pain Specialists of America Affiliate

Office and Financial Policy

I, _____ have read and understand the financial policy and agree to its terms. I understand that insurance billing is a courtesy provided to me by the Ambulatory Surgery Center of Killeen, LLC and I assume full financial responsibility of the balance I incur. I understand co-pays, co-insurance, and deductibles are due at the time of my visit as well as any prior balance I may owe.

_____Initials

I assign benefit to be paid by my insurance company directly to the provider of services rendered to me. Furthermore, should the insurance company issue a check in my name I will notify The Ambulatory Center of Killeen immediately and arrange for payment of my balance. Should I cash any check issued by the insurance company meant for reimbursement of services provided to me, I will assume full responsibility of the balance and will pay the balance within 30 days.

_____Initials

I understand my balance will automatically be referred to an outside collection agency should my account surpass 90 days without payment activity. I agree to pay all reasonable attorneys, collection, or returned check fees in the event of default of payment of my charges or balance arrangements.

_____Initials

I understand that the fees quoted to me for my procedure and any payments made the day of my procedure are for the surgery center only. A statement and bill for the professional fees will be sent separately.

_____Initials

I understand that if I opt for anesthesia services provided by MedStar Anesthesia, for my procedure, that I will be responsible for all co pays, coinsurances and deductibles. I have been informed that this service is billed as out of network with my insurance company.

_____Initials

Notice of Physician Ownership. I understand that Dr. Mehta has a financial interest in the Ambulatory Surgery Center of Killeen, LLC. I am not required to use Ambulatory Surgical Center of Killeen and have the right to choose another facility of my choice. I will not be treated differently by my physician if I choose to use another facility. I acknowledge that I understand this notice of physician ownership, I received it prior to the start of my procedure, and I choose to have my procedure at Ambulatory Surgery Center of Killeen, LLC.

_____Initials

Patients Printed Name	Guarantor's Signature	Date

Witness Printed Name	Witness Signature	Date

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2701 East Stan Schlueter Loop, Killeen Texas 76542

At The Ambulatory Surgery Center of Killeen we specialize in assisting individuals whose chronic pain has not responded to conventional treatments such as bed rest, medication, physical therapy and surgery. Pain that persists for more than three to six months is considered chronic.

Pain often presents itself as low back pain, neck pain, post-operative pain, abdominal pain, joint pain, headaches and pain from cancer. Over 40 million Americans are disabled by chronic pain.

Awareness of the problem of chronic pain has increased dramatically in recent years. Our goal at The Ambulatory Surgery Center of Killeen is to reduce or eliminate pain and to rehabilitate the patient to a productive lifestyle.

We request that all previous pertinent medical records be made available to us at the time of the initial evaluation.

Upon arrival to our office, please bring your new patient forms, your insurance card and list of all medications you are currently taking in the original container. It is your responsibility to bring a referral to our office if your insurance requires it and to keep that referral current for future visits.

Our office policy is that all co-pays and or co-insurance are due at time of service, as well as private pay.

PLEASE GIVE US AT LEAST 24 HOURS NOTICE IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT.

If you have any questions regarding any of the forms or you do not understand our policies, please feel free to contact our office.

Please see attached HIPAA Policies and the Patient Rights and Responsibilities.

_____ _____

Patient/Representative Signature Date

I acknowledge that I have received and/or read the following documents:

- □ Patient Bill of Rights and Responsibilities
- □ The HIPPA Notice of Privacy Practice
- □ Advance directives information/ ASC of Killeen Policy on Advanced Directives

_____ _____

Patient Name (please print) Witness Name (please print)

_____ _____

Patient Signature Witness Signature

_____ _____

Date

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Medication Record/History **Patient Label:**

Allergies and Reactions:_____
_____
_____

Height: _____ Weight: _____ Lbs.

Data Source: ☐ Patient ☐ Family ☐ Care Provider ☐ Pharmacy
☐ Extended Care Facility/Agency ☐ Other ☐ Unable to Obtain Med. History

LIST ALL OF THE FOLLOWING TYPES OF MEDICATIONS:

Prescriptions, OTC, research vitamins, minerals supplements, Nutraceuticals, patches, inhalers, eye drops, herbals, etc.			Medication Resource Information:_____ ☒ None Pharmacy location:_____Phone:_____ Primary Care Physician:_____ Phone:		
List medications patient is taking at home. Medication Name/Strength: ☐ None	Dose	Route	Frequency	Last Taken	Reason for use

Blood Sugar: _____ At: _____ (Within 2 hours of procedure)

Nurse Obtaining Medication History: _____ Date: _____

MD Signature: _____Date: _____

Anesthesia Provider (CRNA) Signature: _____ Date: _____

Patient Signature: _____Date:_____

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PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

1. The patient has a right to receive treatment in the center without regard to race, color, religion, sex, age, handicap, or national origin, without discrimination or reprisal. To help regain or maintain maximum state of health, and if necessary, cope with death. The patient will be treated with consideration, respect, dignity, privacy and full recognition of individual cultural, psychosocial, and spiritual values.
2. The Patient has the right to receive from their physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Where medically significant alternative for care or treatment exist, or when the patient request information concerning medical alternatives, the patient has the right to such information and to know the name of the person responsible for the procedures and/or treatment.
3. The Patient has the right to obtain from their physician complete, current information concerning their diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. When medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
4. The patient will be a participant in decisions regarding the intensity and scope of treatment. Circumstances under which the patient may be unable to participate in his/her plan of care are recognized. In these situations, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.
5. The patient has the right to appropriate assessment and management of pain.
6. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of their action.
7. The patient has the right to obtain information from their medical record for use in other health care and education institutions.
8. The patient has the right to expect that all communications and records pertaining to their care should be treated as confidential.
9. The patient has the right to expect reasonable continuity of care.
   That the patient or responsible person will be informed of the scope of services available in the facility, provisions for after-hours and emergency care, and related fees for services rendered.
10. The patient has the right to examine and receive an explanation of their bill regardless of source of payment.
    The patient has the right to be informed of fees for services as well as payment policies prior to surgery by an insurance counselor.
11. The patient has the right to know that the facility personnel who care for the patient are qualified through education and experience to perform the services for which they are responsible. The patient has the right to request to identify the professional status of all individuals providing service to them.
12. The patient has the right to be informed that they may change primary or specialty physicians if other qualified physicians are available.
13. The patient and family are responsible for providing to their caregivers the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
14. The patient has the right to be advised if the center proposes to engage in or perform human experimentation affecting his/her care of treatments, has the right to refuse participation, and review the decision periodically.
15. The patient has a right to be informed if a health care provider does not have liability coverage.
16. The patient has a right to express grievance and suggestions to the organization. Please contact the administrator.
    - The facility provides for and welcomes the expression of grievance/complaints and suggestions by the patient
      at all times. This feedback allows the facility to understand and improve the patient's care and environment.
    - This is accomplished by filing a written complaint, by calling Hot Line (512) 836-1200 or by contacting any staff member or the Administrator. Resolution will be achieved by the Administrator or Medical Director within 30 days.
    - You may also file a complaint with the Department of State Health Services, Manager, Health Facility Compliance Group, Post Office Box 149347, Austin, Texas 78714-9347, (888) 973-0022.

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17. The patient has a right to have an Advance Directive, such as a living will or health care proxy. These documents express the patient's choices about future care or name someone to decide if the patient cannot speak for himself or herself. The patient who has an Advance Directive must provide a copy to the facility and to their physician for their wishes to be made know and honored.
    Do you have an advance directive ☐ Yes ☐ No

    Patient Signature: _____ Date: _____

18. The patient has the right to be fully informed before any transfer to another facility or organization.

19. The patient or the patient's designated representative has the right to participate in the consideration of ethical issues that arise in the care of the patient.

20. The patient has the right to know the center's rules and regulations that apply to their conduct as a patient.

21. The patient has a right to know that the organization prohibits physical, sexual, and verbal/psychological abuse and harassment.

Thank you for choosing The Ambulatory Surgery Center of Killeen, LLC. In order to inform you of our current financial and office policy, please read the document below and sign the financial agreement. Our providers, clinical, and office staff are here to help you in any way possible and strive to make your experience with us pleasant and comforting. Keep a copy of this document for your records and should you have any questions please do not hesitate to ask one of our associates.

Please keep us informed of any address, telephone number, or name changes. If we are unable to contact you regarding your bill, we will refer the balance to our outside collection agency. Please notify our office within 24 hours to reschedule or cancel an appointment. This will allow our staff to offer this time slot to another patient in need of an appointment.

We accept the following forms of payment: cash, credit cards, cashier's checks, money orders, and personal checks.

Returned Checks

- Returned checks will accrue a $50.00, as well as any applicable bank fees to your account.

Insurance

- It is your responsibility to know your level of benefits for services provided. Being that our providers are specialist, many services are required to have prior authorizations by the insurance company and/or Primary Care Physician. Please contact your insurance company before your appointment to ensure proper authorization and an estimate of payment due as we aren't certain what the patient balance will be until the insurance company processes your claim.
- Payment of fees, co-pays, co-insurance and deductibles are due at the time of service.
- Co-pays are a requirement placed on you by your insurance company and therefore cannot be waived or reduced. Should you forget or cannot provide your co-pay at the time of visit; you will be asked to reschedule your appointment.
- You are solely responsible for your balance in the form of co-insurance, deductible, or non- covered services as required by your insurance company.
- You will be contacted prior to your appointment and notified of any balance due on your account and will be expected to bring payment to your appointment. You will be required to make arrangements with the financial counselor if you cannot pay the balance in full.
- Should any balance remain unpaid more than 90 days past the processing date with the insurance company, a statement will be sent to the guarantor of the account and payment will be due upon receipt of the statement.

Worker's Compensation

- Please keep in contact with your adjuster prior to and after your appointment to receive any pertinent information regarding your claim and injury.
- Authorizations may be required for certain procedures and could take up to 1 week to obtain.
- Should your case become closed, undergo peer review, or determined that Maximum Medical improvement has been met you must contact your referring physician and adjuster for written approval before scheduling any appointment or services.

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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.

Information about you and your health is personal, and we are committed to protecting your privacy. This notice tells you about our privacy practices, the ways in which we may use and share your health information, and how you can get access to your health information. This notice also describes your rights and our responsibilities regarding the use and disclosure of health information.

Our Uses and Disclosures

We typically use and share your health information in the following ways:

Treat you: We can use your health information and share it with other professionals who are treating you. Examples: we will share health information about you with an ambulatory surgical center where you are scheduled for a procedure; we will share your health information with a physician to whom you have been referred for further treatment.

Bill for our services: We can use and share your health information to bill and receive payment from health plans and other entities. Example: we will share your health information with your health insurance plan so it will pay for services we provide to you.

Run our organization: We can use and share your health information to run our operations, train medical students, improve your care and contact you when necessary. Examples: we may call you by name in the waiting room when your physician is ready to see you; we may use your health information in our quality improvement reviews.

We can also de-identify your health information and use and disclose such de-identified information for any purpose.

Communicate regarding treatment alternatives or appointment reminders: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related services that may be of interest to you.

How else can we use or share your health information? We are allowed or required to share your health information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information, see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues: We can share information about you for certain situations, such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Food and Drug Administration (FDA): We may share health information with the FDA relative to adverse events with respect to food, medications, devices, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' comp, law enforcement & other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Please contact the office directly where you receive care.
- We will provide a copy or a summary of your health information in accordance with applicable state and federal requirements. We may charge a reasonable, cost-based fee.

- If you ask that we send a copy of your medical record/other health information to someone other than you, we may ask you to complete a written auth. You may revoke an authorization to use or disclose your health information except to the extent that action has already been taken in reliance on your authorization. To revoke your authorization, send written notice to:
  Privacy Officer, Daniel Frederick, MD
  4100 Duval Road, Bldg 3, Suite 200, Austin, TX 78759. Phone: 855.876.7246

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. You may also view a copy of this notice on our website.

Ask us to limit what we use or share:
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

File a complaint if you feel your privacy rights have been violated.
- You can complain if you feel we have violated your privacy rights by contacting the office where you receive care directly.
- You can also contact our Privacy Officer:
  Privacy Officer, Daniel Frederick, MD
  4100 Duval Road, Bldg 3, Suite 200, Austin, TX 78759. Phone: 855.876.7246
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date: 5/2022