

ADVANCED SURGICAL ARTS CENTER

Consent for Purposes of Treatment, Payment and Health Care Operations, Privacy Practice, Statement of Financial Understanding, and Authorization for Release of Medical Information

I consent to the use or disclosure of my protected health information by Advanced Surgical Arts Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Advanced Surgical Arts Center.

I understand that diagnosis or treatment of me by D'Arcy Honeycutt, M.D., may be conditioned upon my consent as evidenced by my signature on this document.

In consideration of the services rendered to the patient by the provider, the undersigned guarantees the payment of any amount due. All co-pays are due at the time of service. Self-pay balances are due immediately upon receipt of statement. If a payment or contact with our office is not made within 90 days of billing, further collection activity will occur. Advanced surgical Arts Center accepts American Express, Visa, MasterCard and Discover.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Advanced Surgical Arts Center is not required to agree to the restrictions that I may request. However, if Advanced Surgical Arts Center agrees to a restriction that I request, the restriction is binding on Advanced Surgical Arts Center and Dr. D'Arcy Honeycutt.

This signature is valid for one year and I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. D'Arcy Honeycutt or Advanced Surgical Arts Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse, including photographs. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Advanced Surgical Arts Center Notice of Privacy Practices prior to signing this document.

Advanced Surgical Arts Center's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Advanced Surgical Arts Center.

The Notice of Privacy Practices for Advanced Surgical Arts Center is also provided in the office reception area and on the Advanced Surgical Arts Center website at www.darcyhoneycutt.com, Frequently Asked Questions.

This Notice of Privacy Practices also describes my rights and the duties of Dr. D'Arcy Honeycutt with respect to my protected health information. Advanced Surgical Arts Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing Advanced Surgical Arts Center's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Name

Patient's Date of Birth

Signature of Patient or Personal Representative

Date

Relationship to Patient

Signature Witness

PHOTOGRAPH AUTHORIZATION AND RELEASE: I agree to allow use of my image for pre-op patient teaching be shown to other patients contemplating my same surgery Yes _____ No_____ Patient/PR Initials_____

EMAIL AUTHORIZATION AND RELEASE: I agree to allow Advanced Surgical Arts Center to contact me via unencrypted email regarding your health information. Yes _____ No_____ Patient/PR Initials_____

I AUTHORIZE DR.HONEYCUTT AND STAFF OF ADVANCED SURGICAL ARTS CENTER TO RELEASE MY HEALTH INFORMATION TO THE FOLLOWING INDIVIDUALS: _____