North Atlanta Surgical Associates, P.C.

Please Print the Following Information: Date: _____

Name of Patient: _____
First Middle Last

Social Security #: _____ Age: _____ Sex: _____ DOB: _____

Please indicate below what categories you may fall under. You do have an option to defer.

Ethnicity: ☐ White ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Other ☐ Defer

Race: ☐ Hispanic or Latino ☐ Non-Hispanic ☐ Native Hawaiian or other Pacific Islander ☐ Other ☐ Defer

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ French ☐ German ☐ Russian ☐ Japanese ☐ Italian ☐ Defer

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Please circle your preference(s) for receiving communications from our office: Phone: E-Mail: Mail:

Please list below your preferred Pharmacy Name, Location, Phone and Fax #

Employer: _____ Phone: _____

Employer Address: _____

Occupation: _____ E- Mail Address: _____

Spouse's Name: _____ Social Security #: _____

Age: _____ DOB: _____ Employer: _____ Phone: _____

Person Responsible for Bill: _____ Relationship: _____

Social Security #: _____ DOB: _____

Address: _____ Phone: _____

Employer: _____ Address: _____

In Case of Emergency Notify: _____ Relationship: _____

Address: _____ Phone: _____

Reason for visit: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

I authorize NASA to bill by insurance company for charges incurred during the course of treatment and to provide any medical information necessary to process insurance claims. I authorize payment to be made directly to NASA and a copy may be used instead of the original. I authorize my doctor to inquire about my account and to receive any information that may be necessary.
I understand that NASA will file any claims with my insurance company for charges incurred. However, if my insurance company does not have a contract with NASA, I UNDERSTAND THAT I WILL BE PAYING FOR MY VISIT IN FULL.
If my insurance company does have a contract with NASA, I agree that I will be responsible for all non-covered services and pre-existing conditions. I will be responsible for any co-payments and deductibles.

_____ _____ _____
Patient's Signature Guarantor's Signature (If patient is a minor) Date

Patient Name: _____

Date of Birth: _____

Chief Complaint: _____
History of present Illness: _____

Past Medical History

Have you ever had or been treated for:

- ☐ HIV / AIDS
- ☐ Transfusion reaction
- ☐ Sickle cell disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Glaucoma

Musculoskeletal:

- ☐ Back/Neck pain
- ☐ Cane, walker, crutches
- ☐ Leg cramping
- ☐ Artificial arm/leg
- ☐ Muscles weak
- ☐ Arthritis

Skin:

- ☐ Current bruises, rash
- ☐ Current burns
- ☐ Current wounds, sores, ulcers
- ☐ Problems with tape

Cardiovascular:

- ☐ Heart attack
- ☐ Chest pain, angina
- ☐ Irregular pulse
- ☐ Cardiac arrest
- ☐ Congestive heart failure
- ☐ Pacemaker
- ☐ Murmur
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse
- ☐ Anemia
- ☐ Circulation problems
- ☐ Blood clots, phlebitis
- ☐ Free bleeder
- ☐ Hemophilia
- ☐ Bruise easily

Respiratory:

- ☐ Bronchitis
- ☐ Chronic cough
- ☐ Asthma, wheezing
- ☐ Tuberculosis (TB)
- ☐ Sinus problems
- ☐ Emphysema, COPD
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Collapsed lung
- ☐ Home oxygen therapy
- ☐ Tracheostomy

Neurological:

- ☐ Seizures
- ☐ Paralysis
- ☐ Head injury
- ☐ Stroke
- ☐ Spinal cord injury
- ☐ Numbness or tingling
- ☐ Migraine headaches
- ☐ Fainting

Patient Name: _____

Date of Birth: _____

Gastrointestinal:

- ☐ Hiatal hernia, reflux, heartburn
- ☐ Peptic ulcer
- ☐ Bowel disease
- ☐ Diet, food intolerance
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Hepatitis
- ☐ Low blood sugar
- ☐ Swallowing problems
- ☐ Recent vomiting or diarrhea
- ☐ Loss of appetite
- ☐ Recent weight gain/loss
- ☐ Ostomy
- ☐ Gall bladder problems
- ☐ Liver disease

Genitourinary:

- ☐ Kidney stones
- ☐ Difficulty with control
- ☐ Blood in urine
- ☐ Difficulty Dialysis
- ☐ Prostate disease
- ☐ Sexual problems with urination
- ☐ Frequent urine Infections

Breast:

- ☐ Breast Cancer
- ☐ Benign breast disease

(For Breast patients only)

- ☐ Last menstrual period____/____/____(Date)
- ☐ History of hormone replacement therapy
- ☐ Age when your 1st child was born____years old
- ☐ Previous breast biopsy
- ☐ Atypical ductal/lobular hyperplasia
- ☐ Age of menarche
- ☐ Number of pregnancies
- ☐ Number of live births

Other:

_____ _____ _____

Patient Name: _____

Date of Birth: _____

Family Medical History

Family History	Relation
☐ Anemia	_____
☐ Anesthesia problem	_____
☐ Bleeding problem	_____
☐ Cancer	_____
☐ Diabetes	_____
☐ Heart Disease	_____
☐ High Blood Pressure	_____
☐ High cholesterol (Hyperlipidemia)	_____
☐ Kidney diseases	_____
☐ Stroke	_____
☐ Liver disease	_____
☐ Autoimmune disease	_____
☐ Blood clotting disorders	_____
☐ Lung disease	_____

Patient Allergies

Allergies	Severity	Date	Comments

Patient Name: _____

Date of Birth: _____

Smoking Status:

- ☐ Current every day smoker (1)
- ☐ Current some day smoker (2)
- ☐ Former smoker (3)
- ☐ Never smoker (4)
- ☐ Smoker, current status unknown(5)
- ☐ Unknown if ever smoked
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker

If yes, Packs/day:____ Number of Years:____ Quit Date: / /_____

Alcohol Use Status:

- ☐ Does not drink
- ☐ currently drinks
- ☐ Did not ask
- ☐ Former drinker
- ☐ Quit

If yes, Alcohol Type:_____Drinks/Week:_____Quit Date: / /_____

Illicit/Illegal drugs

Status:

- ☐ Does not take drugs
- ☐ Currently takes drugs
- ☐ Did not ask
- ☐ Former drug user.
- ☐ Quit

If yes, Drug Type:_____Quit Date: / /_____

Hospitalization/Surgeries

Surgery/Procedure	Hospital	Date	Comment

Patient Name: _____

Date of Birth: _____

Review of Systems

General

- ☐ Fever/Chills
- ☐ Weight loss

Eyes/Ears/Nose/Mouth

- ☐ Vision Loss
- ☐ Difficulty Swallowing
- ☐ Nosebleeds
- ☐ Hoarseness/Voice Change
- ☐ Hearing Loss
- ☐ Ringing in the Ears

Cardiovascular

- ☐ Chest pain
- ☐ Heart Failure
- ☐ Shortness of Breath
- ☐ Fainting Spells
- ☐ Irregular Heartbeat
- ☐ Swollen Ankles

Endocrine

- ☐ Diabetes
- ☐ Thyroid Disease/Goiter

Respiratory

- ☐ Wheezing
- ☐ Chronic Bronchitis
- ☐ Chronic Cough
- ☐ Asthma
- ☐ Emphysema

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Bloody Stools
- ☐ Black Tarry Stools
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Constipation

Musculoskeletal

- ☐ Arthritis
- ☐ Joint Pain

Integumentary

- ☐ Rashes
- ☐ Pruritus
- ☐ Hives

Neurological

- ☐ Muscle Weakness
- ☐ Numbness/Tingling
- ☐ Sensation

Psychiatric

- ☐ Depression
- ☐ Nervous Breakdown

Genitourinary

- ☐ Kidney Infection
- ☐ Frequent Overnight Urination
- ☐ Blood in Urine

Hematological/Lymphatic

- ☐ Blood Transfusions/Reactions
- ☐ Easy bruising
- ☐ Bleeds Easily/Hemophilia
- ☐ Anemia

Patient Name: _____

Date of Birth: _____

Current Medications

Drug name	Dosage	Quantity	Prescription Date	Prescribed By

North Atlanta Surgical Associates

Patient Financial Policy

Welcome to North Atlanta Surgical Associates (NASA)

We are pleased that you have chosen us to be your provider of surgical care and we are committed to providing you with quality and affordable health care. The following information outlines your financial responsibilities as it relates to payment for services you are to receive.

Insurance - We participate in most insurance plans, including Medicare. If you have a secondary insurance or supplemental policy we will submit claims to both. NASA does not participate with Medicaid. If you are not insured by a plan that we do business with, payment in full is expected at each visit. If you are insured by a plan that we do business with but do not have an up-to-date insurance card on file, payment in full is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Proof of insurance – All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and a valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the charges incurred.

Coverage changes - If your insurance changes, please notify us before your next visit so we can update your records to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days; the balance can be billed to you.

Co-payments and deductibles – All co-payments and deductibles must be paid at the time of service. This arrangement is in compliance with your contract with your insurance company. For your convenience we accept cash, checks, and credit cards. If you pay with a check and it is returned for insufficient funds/closed account you will be charged a fee of $30.00. This fee is in addition to any fees that may be assessed by the bank for returned checks.

Waiver of patient responsibility - It is the policy of NASA to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers.

Non-covered services – Please be aware that some services you receive may be non-covered or not considered reasonable or necessary by your insurer. You must pay for these services in full prior to or at the time of visit.

Claims submission – We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

North Atlanta Surgical Associates

Patient Financial Policy

Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

Non-payment - If your account is over 90 days past due, we may refer your account to a collection agency. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for collections costs including attorney fees and court costs. Additional appointments may not be scheduled until your account is returned to good standing. Partial payments will not be accepted unless otherwise negotiated.

For our patients with no medical insurance - If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit. Please note, we do offer discounted fees for patients without health insurance. In order to receive the discount, payment must be made in full at the time of service.

Surgical Patients – All procedures which are cancelled/rescheduled within 5 days of the surgery date will be charged a $150.00 non-refundable administration fee. (Unless cancelled by Physician)

Managed Care Patients/Referrals and Authorizations- I understand that I am required to obtain proper referral and/or authorization as required by my insurance plan prior to my appointment with any of the NASA Physicians. If authorization is not obtained for my visit my insurance may not pay for my treatment. If this is the case I will be responsible for any charges incurred. I understand that NASA is not obligated to see a patient without a valid referral/authorization.

If my insurance plan sends me a check for payment of the medical services provided by NASA, the check belongs to NASA and I must immediately deliver the check to NASA for payment on my account. In the event that my insurance plan denies my claim and I choose to appeal their decision, this form and my signature authorizes my Physician to submit an appeal along with any necessary medical information to my insurance plan.

Our practice is committed to providing the best treatment to our patients. Thank you for your understanding of our financial policy and please let us know if you have any questions or concerns.

I have read and understand the patient financial policy and agree to abide by it guidelines:

_____ _____

Signature of patient/responsible party Date

Revised 10/2019

MEDICARE PAYER QUESTIONNAIRE

There may be situations where Medicare is not your primary payer or Medicare coverage policies vary.
Medicare law requires that we investigate all possible situations where other insurance, besides Medicare, might be the primary payer.
This Questionnaire must be completed by any patient who may be eligible for Medicare as primary or secondary.
If Medicare has been replaced by another plan section II will need to be completed.
We appreciate your help by completing this questionnaire.

Patient Name: _____ Date of Birth: _____

Responses Section I

□**Yes** □**No** 1. Are you currently receiving any Home Health Services (including nursing, bathing or dressing assistance, injections or respiratory services)?

□**Yes** □**No** 2. Are you covered under a Medicare Part C (Medicare Advantage/Medicare+ Choice) program?
If YES, enter the name of the health plan: _____

□**Yes** □**No** 3. Was your illness or injury due to a work-related accident or condition?
If YES, enter the date of illness or injury: _____
Provide the name of your employer on the Patient Registration Form.

□**Yes** □**No** 4. Was your illness or injury due to a non-work-related accident?
If YES, enter the date of illness or injury: _____
If no-fault, auto, or liability insurance is available, enter information in Section II.

□**Yes** □**No** 5. If you are entitled to Medicare based upon Age or Disability, are you currently employed?
If YES, provide your employer's information on the Patient Registration form.
If NO, enter your retirement date: _____ □ Never Employed

□**Yes** □**No** 6. Do you have a spouse who is currently employed?
If YES, provide your spouse's employer's information on the Patient Registration form.
If NO, enter your spouse's retirement date: _____ □ Never Employed

□**Yes** □**No** 7. Do you have group health plan coverage based upon your own or your spouse's employment?
If YES, enter your and/or your spouse's group health plan information in Section II

□**Yes** □**No** 8. Are you entitled to Medicare due to End Stage Rental Disease (ESRD)?
If YES, enter the date of the kidney transplant: _____ □ No Transplant
If YES, enter date that dialysis began: _____ □ No Dialysis

□**Yes** □**No** 9. Are you receiving Black Lung (BL) Benefits?
If YES, enter date benefits began: _____

□**Yes** □**No** 10. Are services to be paid by a research program?

□**Yes** □**No** 11. Have you needed a kidney transplant or are you on dialysis?

Section II (Please provide us with your insurance card.)

Type of Insurance Coverage □ Workers Compensation □No-fault, Auto, or Liability □ Group Health Plan

Insurance Name _____
Street Address _____
City, State Zip _____
Phone Number _____
Policy Number _____
Group Number _____
Name of Policy Holder _____

If Group Health Plan, approximate number of employees: □ 1-19 □ 20-99 □ 100 or more

I certify all of the information provided herein is true and correct.

_____ _____
Signature of Patient/Representative **Date**

NASA Patient Identification Policies

Important Information for New Patients

NASA policy requires all healthcare staff to obtain, verify, and record information that identifies each new patient.

This policy is for your protection. Identity thieves use people's identifying information to request health care services. This misuse of your information may result in declined healthcare coverage or financial responsibility for services not rendered to you.

What this means for you: When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.
We may request that you allow us to take a digital photo of you for our records and your protection.

North Atlanta Surgical Associates will obtain, verify, and record the following information on new patients.

□ Name
□ Address
□ Driver's License # and State
□ Other Photo ID
□ Date of Birth
□ Social Security/TIN
□ Insurance ID
□ Other supporting documentation if needed

If identification is not possible during an emergency situation you will not be denied medical care. It will be the responsibility of the patient to provide North Atlanta Surgical Associates appropriate identification as required by our Policy.

I certify I am who I claim to be. I have provided documentation supporting claims and my information was verified by North Atlanta Surgical Staff. It will be my responsibility to inform NASA of any changes in my personal information upon future visits.

Patient's Signature: _____ Date: _____

For Internal Office Use Only

I have followed NASA Policy in obtaining, verifying, and recording this patient's identification.

Staff Signature: _____ Date: _____

Updated 07/2020

Authorization for Release of Information

Name of Patient: _____ **Date of Birth:** _____

Please check the appropriate boxes below as they apply to our ability to communicate Protected Healthcare Information with you and or family members/others regarding your appointments, results, financial information and any other medical information pertaining to the care you received by North Atlanta Surgical Associates.
If you do not check any of the boxes, we cannot leave a message, e-mail, or discuss with anyone the information pertaining to your care. This would include your appointments, results, financial information and any other medical information pertaining to the care you received by North Atlanta Surgical Associates.

North Atlanta Surgical Associates is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. Circumstances may arise where obtaining a signed release may be difficult. As the patient, you do have an option to allow verbal authorization for release of information for you and those parties you have listed below. If you will permit verbal authorizations, please acknowledge who and what you want disclosed below.

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as checked below. **I UNDERSTAND** that the following records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

Person or entity to receive information

Check each the mode of communication and the person/entity that you approve to receive information.

- ☐ Live Phone Conversation
- ☐ Voice Mail
- ☐ Secure E-Mail
- ☐ Mail or Courier
- ☐ Fax

Other: _____

☐ Spouse/Significant Other (provide name below)

_____

☐ Parent/Family Member (provide name below)

_____

Other Entity (provide name below)

_____

Description of information to be released

Check each item that can be given to each person/entity on the left of this section.

- ☐ All Records
- ☐ Test results-Labs, Pathology, Diagnostic and or X-Ray
- ☐ Consultation Notes, History and Physical Notes
- ☐ Encounter Forms
- ☐ Mental Health Information
- ☐ Alcohol/Substance Abuse Treatment
- ☐ HIV/Aids Information
- ☐ STD Information
- ☐ Demographics
- ☐ Financial Information
- ☐ Other:

_____

Patient Information:

I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I release North Atlanta Surgical Associates from any and all legal liability that may arise from the release of this information to the party named above. I understand that I have the right to refuse this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until I revoke it. If I decide to revoke it I will submit a revocation in writing. This form will be valid with no expiration unless a shorter time period is listed below. If you leave the second date blank this will be an ongoing authorization. My Authorization is valid from the dates below.

_____ **to** _____

MM/DD/YYYY **MM/DD/YYYY**

_____ **Date:** _____

Signature of Patient or Personal Representative Description of Personal Representative's Authority (attach necessary documentation)

NORTH ATLANTA SURGICAL ASSOCIATES, P.C.
PATIENT ACKNOWLEDGMENT RECEIPT OF NOPP, FINANCIAL POLICY, PATIENT RIGHTS, & ADMINISTRATIVE FEES

I have been offered a copy of the following NASA, P.C. policies

Notice of Privacy Practices

Patient Rights & Responsibilities

Administrative Fees

By signing below, I acknowledge that I have read and have been offered all of the policies listed above for North Atlanta Surgical Associates, P.C.

_____
Signature of Patient or Representative

_____
Printed Name

_____
Relationship of Representative to Patient

_____
Description of Representative's authority to act on behalf of Patient

_____
Date

Updated 07/2020

NORTH ATLANTA SURGICAL ASSOCIATES, P.C.

www.northatlantasurgery.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At North Atlanta Surgical Associates, P.C. ("NASA"), we are committed to treating and using protected health information ("PHI") about you responsibly. This Notice of Privacy Practices ("Notice") describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice has been updated in accordance with the HIPAA Omnibus Rule and is effective March 23, 2013. It applies to all PHI as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit NASA; 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 may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, your health insurer or an outside collection agency.
- Assess and continually work to improve the care we render and the outcomes we achieve.
- Comply with state and federal laws that require us to disclose your PHI.

Understanding what is in your record and how your PHI is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your PHI, and make more informed decisions when authorizing disclosure to others.

You're Health Information Rights

Although your health record is the physical property of NASA, the information belongs to you. You have the right to request to:

- Access, inspect and copy your health record. NASA maintains an electronic medical record ("EMR"). You have the right to access your health record in a machine readable electronic format. You have the right to request an electronic copy of your medical record be given to you or transmitted to another individual or entity.
- Amend your health record which you believe is not correct or complete. NASA is not required to agree to the amendment if you ask us to amend information that is in our opinion: (i) accurate and complete; (ii) not part of the PHI kept by or for NASA; (iii) not part of the PHI which you would be permitted to inspect and copy; or (iv) not created by NASA, unless the individual or entity that created the information is not available to amend the information. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.
- Obtain an accounting of disclosures of your PHI. We are not required to list certain disclosures, including (i) disclosures made for treatment, payment, and health care operations purposes, (ii) disclosures made with your authorization, (iii) disclosures made to create a limited data set, and (iv) disclosures made directly to you. Communications of your PHI by alternative means (e.g. e-mail) or at alternative locations (e.g. post-office box).
- Place a restriction to certain uses and disclosures of your information. In most cases NASA is not required to agree to these additional restrictions, but if NASA does, NASA will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). NASA must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.
- Revoke your authorization to use or disclose PHI except to the extent that action has already been taken.

Our Responsibilities

NASA is required to:

- Maintain the privacy of your PHI.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collectand maintain about you.
- Abide by the terms of the Notice currently in effect
- Notify you in writing if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate PHI by alternative means or at alternative locations.
- Notify you in writing of a breach where your unsecured PHI has been accessed, acquired, used or disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you.

We will not use or disclose your PHI without your written authorization, except as described in this Notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact:

Privacy/Security Officer
North Atlanta Surgical Associates, P.C.
980 Johnson Ferry Rd, NE Suite 880
Atlanta, Georgia 30342
Telephone: (404) 255-8304
www.northatlantasurgery.com

If you believe your privacy rights have been violated, you can file a written complaint with NASA's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Treatment: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, NASA operates an Electronic Medical Records System. This is a system that stores Proctected Healthcare Information about you.

NASA may also provide a subsequent healthcare provider with PHI about you (e.g., copies of various reports) that should assist him or her in treating you in the future. NASA may also disclose PHI about you to, and obtain your PHI from, electronic PHI networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

Health Care Operations: We 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 health care and service we provide.

Business Associates: We may contract with third parties to perform functions or activities on behalf of, or certain services for, NASA that involve the use or disclosure of PHI and disclose your PHI to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

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 from Offices: We may call your home or other designated location and leave a message on voice mail or in person regarding any items that assist NASA in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist NASA in carrying out Treatment, Payment and Health Care Operations.

Communication with Family/Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany you into the exam-room, it is considered implied consent that a disclosure of your PHI is acceptable.

Open treatment areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer.

To Avert a Serious Threat to Health or Safety: We may use your PHI or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual. NASA may use a single compound authorization to combine conditioned and unconditioned authorizations for research (e.g. participation in research studies, creation or maintenance of a research database or repository), provided the authorization: (i) clearly differentiates between the conditioned (provision of research related treatment is conditioned on the provision of a written authorization) and unconditioned research components; and (ii) provides the individual with an opportunity to opt in to the unconditioned research activities.

Coroners, Medical Examiners and Funeral Director: In the unfortunate event of your death, we may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Deceased Individuals: In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment for your care prior to your death, unless inconsistent with any prior expressed preference that you provided to us. PHI excludes any information regarding a person who has been deceased for more than 50 years.

Organ Procurement Organizations: Consistent with applicable law, we may disclose PHI to organ procurement organizations, federally funded registries, or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.

Fund Raising: We may contact you as part of a fund-raising effort. We may also disclose certain elements of your PHI, such as your name, address, phone number and dates you received treatment or services at NASA, to a business associate or a foundation related to NASA so that they may contact you to raise money for NASA. If you do not wish to receive further fundraising communications, you should follow the instructions written on each communication that informs you how to be removed from any fundraising lists. You will not receive any fundraising communications from us after we receive your request to opt out, unless we have already prepared a communication prior to receiving notice of your election to opt out.

Sale of your PHI: NASA may not "sell" your PHI (i.e., disclose such PHI in exchange for remuneration) to a third party without your written authorization that acknowledges the remuneration unless such an exchange meets a regulatory exception.

Health Oversight Activities: We may release your PHI to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

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.

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

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

Law Enforcement: We may disclose PHI for law enforcement purposes as required by law.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety at the place where you are confined.

Lawsuits and Disputes: We may disclose your PHI if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

As Required by Law: We may use or disclose your PHI if we are required by law to do so.

North Atlanta Surgical Associates, PC

Patient Rights and Responsibilities

North Atlanta Surgical Associates does not discriminate on the basis of race, color, national origin, age, disability, sex, or sexual orientation. North Atlanta Surgical Associates does not exclude people or treat them differently because of race, color, national origin, age, disability, sex or sexual orientation.

You Have A Right:

- To be treated with respect, consideration, and dignity at all times.
- To receive assistance in a responsible manner.
- To receive information about your health including your diagnosis, treatment, testing or procedures and medical alternatives including associated risks that may be involved in your healthcare. This information can be obtained by requesting physical copies or access to your secure electronic chart.
- To know the identity and professional status of individuals providing services to you.
- To expect that your medical records and communications will be treated in a confidential manner. To
- refuse treatment and be advised of the alternatives and likely consequences of your decision. To
- be provided a free qualified interpreter language service to you if your primary language is not English.
- To be provided a free qualified interpreter if you are deaf.
- To express a complaint to the office manager, physician or staff.

You Have A Responsibility:

- To complete an Authorization for Release of Information Form
- To review and understand your health insurance coverage and benefits.
  To learn and understand the proper use of your insurance plan services and procedures for obtaining coverage. This includes knowing the referral policy for your plan, laboratory restrictions, and outpatient facilities covered by your plan as well as co-pay requirements.
- To always carry your insurance plan identification card and be prepared to show it at each office visit. Patients will be required to pay for all services provided if insurance information is not provided by the patient at the time services are rendered or the information provided is inaccurate.
- To treat all office personnel respectfully and courteously.
  To keep scheduled appointments and to notify the office promptly if you will be delayed or unable to keep an appointment. (24-hour notice)
- To pay all charges for co-payments, deductibles, non-covered benefits of services at the time of your visit unless prior arrangements have been made.
- To ask questions and seek clarification until you fully understand the care you are receiving.
- To follow the advice of your medical provider and consider the alternatives and/or likely consequences if you refuse to comply.
  To provide honest and complete information to those providing medical care.
- To express your opinions, concerns, or complaints in a constructive and appropriate manner.

If for some reason you have a comment or concern regarding any of the mentioned above please call 678-387-2945. Comments or Concerns can also be E-Mailed to complianceconcerns@nasasurgeryatl.com

Notice of Office Administrative Fees

North Atlanta Surgical Associates, P.C. charges administrative fees for the following forms:

Annual Fee $75.00 (optional-waives all other fees for one year)

Disability forms $25.00 (per form) Account history $15.00 (per form)

Medical Records –Charges per Georgia Law:

GEORGIA STATE COPY LAW

SECTION 2: CODE SECTION: 31-33-3

The party requesting the patient's records shall be responsible to the provider for the reasonable costs of copying and mailing the patient's record. The actual cost of postage incurred in mailing the requested records may also be charged, in addition copying costs for a record which is in paper form shall not exceed$.97 per page for the first 20 pages of the patient's record which are copied. $.83 per page for pages 21 through 100 and $.66 for each page copied in excess of 100 pages. All of the fees allowed by this code section may be adjusted annually in accordance with the medical component of the consumer price index. A charge of $25.88 may be collected for search retrieval and other direct administrative costs related to the request under this chapter.

Administrative Costs (e.g., search, retrieval and other labor costs)	$25.88
Certifying the Copies	up to $9.70 per record
Cost of Postage	Actual Charges
First 20 pages of patient's record	up to $.97 per page
Pages 21 through 100 of record	up to $.83 per page
Each page over 100 pages	up to $.66 per page