PROLIANCE SURGEONS®

THREE RIVERS EAR, NOSE & THROAT
925 Stevens Drive Suite 1A Richland WA, 99352 P(509) 946-9220 F(509) 946-9151
7105 W. Hood Pl Suite A 103 Kennewick WA, 99336 P(509) 735-5551 F(509) 735-5552

Authorization to Leave Personal Health Information by Alternate Means

Patient Name: ______________________________ Date of Birth: ____________

Patient Mailing Address: ____

____

(Please check all that apply)

☐ May leave detailed message on voicemail at home #: ( ) ____________________

☐ May leave detailed message on voicemail at work #: ( ) ____________________

☐ May leave information with spouse (name): ____________________

☐ May leave information with other family member (name): ____________________

☐ May leave detailed message on cellular phone #: ( ) ____________________

☐ May leave detailed message at a different location #: ( ) ____________________

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

____

Patient or legally authorized individual signature   Date

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NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

____
Signature of patient OR patient's authorized representative Date signed

____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

THIS AREA FOR STAFF NOTES:

THIS FORM WILL BE RETAINED IN YOUR MEDICAL RECORD.

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FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you and by providing us with updated personal and financial information promptly following a change. The following is a summary of our written Financial Policy. We can provide you a copy of this Financial Policy upon your request. If you have questions regarding this Financial Policy, please speak with one of our Financial Coordinators.

New 'Self Pay' Patients

If you have no health insurance coverage and are a NEW patient, a minimum down payment of $150 is required at the time of your first appointment. Payment must be made with cash or credit card only. No checks allowed. You will be contacted by our Business Office to establish a formal payment plan for your remaining balance. Your consult could cost less than $150, in that case you may possibly be refunded at the time of your visit, or the money could go towards your next visit or surgery.

Payments are Due at the Time of Service

We will bill your health plan, for those in which we participate and are contracted. Copayments are due at the time services are rendered. We accept VISA, MasterCard, AMEX, Discover, Money Order, Cash and Personal Check. If you do not have insurance or a health plan in which we participate, you are responsible for the total charge, due at the time of services. We offer cash discounts upon request.

Outstanding Balances

We realize that our patients have financial difficulties. Patients with an outstanding balance must make arrangements for payment prior to scheduling appointments. There is a service fee of $10.25 imposed on any balances thirty-one (31) days and older.

Referrals

If you are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from your primary care physician before making an appointment.

Surgical Procedures

Prior to any surgical procedure, we will attempt to provide an estimate of amounts due to **Three Rivers Ear, Nose & Throat**. This is only an estimate based on information we receive from your health plan regarding your benefits and unmet deductibles and coinsurances. Your estimated portion is payable prior to your surgery date. After the procedure and once your health plan has paid its portion, any remaining balance will be billed to you and is due and payable. Please keep in mind that estimated charges might change if findings during the procedure are more extensive than assumed at the time of estimate.

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Returned Checks

There is a $50.00 service fee for returned checks, after which we can no longer accept your check as a form of payment for a period of six (6) months.

Missed Appointments/Late Cancellations

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment time. If you miss an appointment without providing 24 hour notice, we reserve the right to charge a missed appointment fee of $25.00. Excessive missed appointments or late cancellations may result in discharge from the practice.

Refunds

If we have over-collected a payment, we will send you a refund after any other outstanding account balance is paid.

Non-Covered Services

Your insurance plan may not cover all of the serves we can provide to you. If a service you received is not a covered benefit, you will be financially responsible. We will use our best efforts to attempt to inform you in advance. If your procedure is cosmetic, an excision of a lesion, lump, and skin neoplasm etc, we may ask you to sign an Advance Beneficiary Notice (ABN) prior to receiving services.

Assignment and Agreement

I have read and understand **Three Rivers Ear, Nose & Throat** / Proliance Surgeons Financial Policy, and agree to its terms. I hereby assign all medical/surgical benefits to **Three Rivers Ear, Nose & Throat** and Proliance Surgeons who may bill certain insurance companies as a courtesy to me, and authorize a release of all information necessary to secure the payment of benefits. I understand that I am responsible for the bill for all services rendered to me or my dependents by **Three Rivers Ear, Nose & Throat** /Proliance Surgeons regardless of whether I have insurance and regardless of how much my insurance might pay. Any copayments, deductibles and non-covered charges that might apply will be paid at the time services are rendered unless other arrangements are specifically made in advance and late fees will be imposed on any balances older than sixty (60) days.

Signature of
Patient / Responsible Party: ______________________________ Date:____________

NOTICE OF PRIVACY PRACTICES

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.

Proliance Surgeons, Inc., P.S. respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment plans, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may contact you during negotiations with your health insurance carrier or to inform you of changes with our relationship to your health insurance carrier.
- We may use and disclose your information to conduct or arrange for services, including:
  - medical quality review by your health plan;
  - accounting, legal, risk management, and insurance services, and
  - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted.
- Request and receive from us a paper copy of this or the most current Notice of Privacy Practices for Protected Health Information ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this Notice, and
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you please contact the administrator of the location at which you have been treated.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also contact the administrator at any of our practice/health care facilities or Proliance Surgeon's privacy office at (206)838-2590. You may also contact the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers**—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply With Workers' Compensation Laws**—if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
  - to prevent or reduce a serious, immediate threat to the health or safety of a person, or the public, and
  - to public health or legal authorities;
    - to protect public health and safety
    - to prevent or control disease, injury, or disability

- to report vital statistics such as births or deaths.

- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Electronic Health Record

- To promote quality of care, we use an electronic health record that shares health information among many providers and that is owned and operated by Swedish Health Services, a Washington non-profit corporation. This computer system is used by many providers including those not affiliated with us. This electronic health record lets us and other providers look at and/or add information about you, your health, the care you receive, and other important facts. Not all your information is kept in the electronic health record. Not every provider that treats you looks at or adds information in the electronic health record. We cannot remove information once it is placed in the electronic health record.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Web Site

- We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at this address: www.proliancesurgeons.com.

Effective: April 14, 2003 (Revised: September 30, 2011)