DALLAS SURGICAL GROUP

PATIENT NAME: LAST_____FIRST_____MI____ AGE____ SEX F____ M____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

DATE OF BIRTH: ___/___/___ SOCIAL SECURITY # _____ EMAIL:_____

HOME PHONE #_____ CELL PHONE #_____

YOUR EMPLOYER_____OCCUPATION_____

WORK PHONE # _____

NAME OF SPOUSE/SIGNIFICANT OTHER: _____ DOB_____ CONTACT #_____

REFFERING PHYSICIAN_____ PRIMARY CARE DOCTOR_____

OB/GYN_____

EMERGENCY CONTACT_____ RELATIONSHIP_____

ADDRESS OF CONTACT_____ BEST PHONE #_____

I GIVE PERMISSION TO ALLOW DALLAS SURGICAL GROUP TO LEAVE MESSAGES REGARDING MY MEDICAL CARE WHICH MAY INCLUDE PATHOLOGY AND RADIOLOGY RESULTS ON MY:
____ Home Answering Machine ____Cell Phone ____Work Voicemail ____Email ____Other (_____)

I DO NOT GIVE PERMISSION TO ALLOW DALLAS SURGICAL GROUP TO LEAVE MESSAGES REGARDING MY MEDICAL CARE WHICH MAY INCLUDE PATHOLOGY AND RADIOLOGY RESULTS ON MY:
____Home Answering Machine ____Cell Phone ____Work Voicemail ____Email ____Other (_____)

HEALTH INSURANCE NAME_____ INSURED'S NAME_____

ID #_____ GROUP #_____ INSURER DOB____/____/____

DO YOU HAVE SECONDARY INSURANCE? _____YES _____NO

HEALTH INSURANCE NAME_____ INSURED'S NAME_____

ID #_____ GROUP #_____ INSURER DOB ____/____/____

ASSIGNMENT OF BENEFITS

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE COMPANY BENEFITS BE MADE ON MY BEHALF TO DALLAS SURGICAL GROUP FOR ANY MEDICAL SERVICES FURNISHED TO ME BY DALLAS SURGICAL GROUP. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.

RELEASE OF MEDICAL RECORDS

I AUTHORIZE DALLAS SURGICAL GROUP TO RELEASE ANY AND ALL MEDICAL INFORMATION ABOUT ME TO MY INSURANCE COMPANY OR THIRD PARTY ADMINISTRATOR, FOR THE ADJUDICATION AND PAYMENT OF MY MEDICAL CLAIMS.

FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT ALL PROFESSIONAL SERVICES RENDERED ARE MY ULTIMATE RESPONSIBILITY EVEN IF A THIRD-PARTY ARRANGEMENT HAS BEEN MADE WITH DALLAS SURGICAL GROUP.

SIGNATURE_____ DATE_____

Patient's Name _____

Date _____

Please list all the physicians that you would like us to send letters to regarding your visit with Dr. Beitsch.

	Doctor Name	Phone Number	Address
1)			
2)			
3)			
4)			
5)			

DALLAS SURGICAL GROUP

Medical Records Release Form

This authorizes _____ to provide a copy, summary, or narrative of my medical records (as indicated by the checkmarks) or authorizes release of any pertinent confidential information.

- o Complete medical records
- o Records of care from the following dates: _____ to _____
- o Records concerning the following condition(s): _____
- o Other: _____
- o Confer orally with the person listed below about my medical record.

Patient Name: _____

Date of Birth: _____

Social Security #: _____

Please release to the following person:

Dr. Peter D. Beitsch
8140 Walnut Hill Lane
Suite 800
Dallas, Texas 75231
Phone: (214) 350-6672
Fax: (214) 452-5642

Patient Signature _____ Date ___/___/___

DALLAS SURGICAL GROUP
Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Dallas Surgical Group creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notices and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations with out my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Patient's Name Printed _____ Date _____

Patient's Signature (or guardian if a minor) _____ SS# _____

Witness (Optional) _____ Date _____

Revised: March 24, 2010

Dallas Surgical Group
DR. PETER D. BEITSCH

DISCLOSURE OF PHYSICIAN'S OWNERSHIP INTEREST IN NORTH CENTRAL SURGICAL CENTER, L.L.P., A HOSPITAL

Due to my concern over improving the quality of care and controlling the costs of medical procedures, I, along with a number of other physicians, have invested in North Central Surgical Center, L.L.P., and the Limited Liability Partnership that operates the Hospital. North Central Surgical Center is located at 9301 North Central Expressway, Suite 100, Dallas, Texas, 75231.

This investment provides me an opportunity to be actively involved in the quality control over your medical procedures and to insure that your medical costs are reasonable. My ownership interest in North Central Surgical Center, L.L.P., however, does mean that I may benefit from choosing to perform surgical procedures on you at this facility. Because of this, I hereby advise you that you have the right to choose to be treated at some other facility in which they provide services, I will make arrangements for such an alternative should you so desire.

I have received and read a copy of the Physicians Ownership Disclosure.

Date: _____

Name: _____

Dallas Surgical Group

Authorization Form Policy

Effective Date of Policy: _____

A patient's protected health information ("PHI") will only be released from Dallas Surgical Group with a properly executed Authorization for Use and Disclosure of Health Information form signed by the patient or his/her personal representative, except for treatment, payment, or health care operations, and as otherwise required by law.

Circumstances in which we are required to disclose a patient's PHI include (i) public health activities, (ii) information regarding victims of abuse, neglect, or domestic violence, (iii) health oversight activities, (iv) judicial and administrative proceedings, (v) law enforcement purposes, (vi) organ donation purposes, (vii) research purposes under certain circumstances, (viii) national security and intelligence, (ix) correctional institution purposes, and (x) Worker's Compensation.

Dallas Surgical Group will only use or disclose a patient's PHI, except as noted above, consistent with the terms of the Authorization Form.

A patient may revoke his/her authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If the patient's authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorization forms must be properly executed by the patient or his/her personal representative. The form should include:

(i) the date signed,

(ii) specific PHI to be released or used,

(iii) to whom the use or disclosure relates, and

(iv) an expiration date for the authorization.

Dallas Surgical Group

PLEASE NOTE: This Authorization for Use is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations thereto, as amended from time to time (collectively referred to as "HIPAA"). THIS AUTHORIZATION AFFECTS YOUR RIGHTS IN THE PRIVACY OF YOUR PERSONAL HEALTHCARE INFORMATION. PLEASE READ IT CAREFULLY BEFORE SIGNING.

Authorization for Use and Disclosure of Health Information

Patient Name:					
Address:					
City:		State:		Zip:	
Phone:		Date of Birth:			

1. I hereby authorize the use or disclosure of the above named Patient's protected personal health information ("PHI") as described below.

2. The type and amount of information to be used or disclosed is as follows: *(include dates where appropriate)*

_____ Complete health records
_____ Lab results
_____ Consultation reports
_____ Other: _____
_____ Physical examination
_____ X-rays
_____ Immunization records

3. Dallas Surgical Group or its Business Associates is authorized to make disclosure of the above information to the following recipient:

Name:
Address:

For the purpose of: _____

4. I understand that information in the information being disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. I acknowledge that I have been provided with a copy of, and have read and understood Dallas Surgical Group's Privacy Notice, which contains a complete description of my rights and the permitted uses and disclosures under HIPAA.

6. I understand that I have the right to revoke this Authorization, in writing, at any time, except to the extent that Dallas Surgical Group has taken action in reliance upon it. I understand that, in order for the revocation to be effective, I must present my written revocation to Dallas Surgical Group together with a copy of the executed Authorization form. I understand that any such revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, this Authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this Authorization will expire in _____ days.

8. I understand that authorizing the use or disclosure of this health information is voluntary, and that I have the right to refuse to sign this Authorization. I need not sign this form in order to assure treatment, enrollment in a health plan, or eligibility for benefits.

9. I understand that, in accordance with my rights, and subject to certain restrictions imposed by HIPAA, I may inspect or copy my PHI for as long as the PHI is maintained in Dallas Surgical Group's records.

10. I acknowledge and agree that any information used or disclosed pursuant to this Authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

11. I understand that Dallas Surgical Group will provide me / _____ *[name of patient]* with a copy of this signed Authorization.

Acknowledged and agreed to by:

PATIENT:

_____ _____
Signature of Patient Signature of Witness

_____ _____
Date Date

or, ON BEHALF OF PATIENT:

_____ _____
Signature of Legal Representative Signature of Witness

_____ _____
Date Date

_____
Print Name

_____

_____
Address