AmbulatorySurgeryCenter
KILLEEN

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. This is to inform you that Dr. Mahendru has a financial interest in Ambulatory Surgery Center of Killeen and Medstar Anesthesia and Dr. Mehta has a Financial interest in the Ambulatory Surgery Center of Killeen, LLC.

_____Initials

_____

Patients Printed Name Guarantor's Signature Date

_____

Witness Printed Name Witness Signature Date

2701 East Stan Schlueter Loop, Killeen Texas 76542

Ambulatory Surgery Center
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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

2701 East Stan Schlueter Loop, Killeen Texas 76542

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	

This is to inform that Vivek Mahendru, M.D and Dr. Mehta have a financial interest in the Ambulatory Surgery Center of Killeen, LLC You are free to choose any facility obtaining services that are ordered for you. Our staff will be happy to discuss alternatives with you.

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 and insurance counselor.

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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 (and) 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 or by contacting any staff member or the Administrator. Resolution will be achieved by the Administrator or Medical Director within 30 days.

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 what the center's rules and regulations that apply to their conduct as a patient.

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

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 estimate of payment due as we are not 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.

HIPAA
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 CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice effective as of April 1, 2007 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy has been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257
Toll Free: 1-877-696-6775