The Hand & Plastic Surgery Center of Katy

23960 Katy Freeway, Suite 380, Katy, TX 77494
Tel 832-232-4263 Fax 844-342-4263
www.handandplasticskaty.com

Patient Demographic Information

PATIENT NAME:			Male ☐ Female ☐	AGE	DATE OF BIRTH:
ADDRESS:			SOCIAL SECURITY NUMBER:		
CITY:	STATE:	ZIP:			
EMAIL ADDRESS:			PREFERRED METHOD OF APPOINTMENT REMINDER: PHONE CALL ☐ TEXT ☐ EMAIL** ☐		
EMERGENCY CONTACT:		RELATIONSHIP TO PATIENT:		PHONE:	

PATIENT'S EMPLOYER:		OCCUPATION:	
WORK PHONE:	IS IT OK TO CALL YOU AT WORK? YES ☐	NO ☐	
ADDRESS:	CITY:	STATE:	ZIP:

HEALTH INSURANCE COMPANY:		
POLICY #:		GROUP #:
POLICYHOLDER NAME:	RELATIONSHIP TO PT:	EFFECTIVE DATE:
INSURANCE PHONE:	OFFICE COPAY & AMOUNT:	

SECONDARY HEALTH INSURANCE COMPANY:		
POLICY #:		GROUP #:
POLICYHOLDER NAME:	RELATIONSHIP TO PT:	EFFECTIVE DATE:
INSURANCE PHONE:	OFFICE COPAY & AMOUNT:	

PHARMACY:	PHONE:
ADDRESS:	CITY, STATE, ZIP

** **EMAIL POLICY**: For routine, ***non-emergency*** questions or concerns, you may email us at **office@HandAndPlasticsKaty.com**. Please allow up to 24 hours for a response (excluding weekends & holidays). Include your name, date of birth, return telephone number, and concern in the email. We ask that you acknowledge receipt of any email coming from this office. Please note that any email sent to the office will be processed by the office staff and will be seen by people other than your physician. While we are dedicated to keeping your protected health information confidential, we cannot guarantee any breaches in confidentiality beyond the office's control.

Assume that your email has not been reviewed until you get a response email. If more than 2 business days have passed, please call the office at 832-232-4263.

Signers Name:_____Date: _____

Signature required on page 9.

Practice Representation & Financial Policies

Practice Representation:

Plastic and Hand Surgeons of Katy PLLC (PHS) is managed by and maintains a licensing agreement with The Hand & Plastic Surgery Center of Katy PLLC. Accordingly, PHS assumes the name The Hand & Plastic Surgery Center of Katy. I understand that any services rendered by the practice will be under the auspices of PHS and will hold harmless The Hand & Plastic Surgery Center of Katy PLLC for any liability or action of PHS.

Assignment of Benefits:

I hereby authorize the physicians and staff of Plastic and Hand Surgeons of Katy PLLC to render services to me or my dependents. I further authorize Plastic and Hand Surgeons of Katy PLLC to release my Protected Health Information by phone, email, or fax for purposes of treatment, payment, or procedures. I assign and authorize payment of medical or surgical benefits directly to Plastic and Hand Surgeons of Katy PLLC. I agree to forward to the practice, upon receipt, any insurance or third-party payments I directly receive for services rendered to me or my dependent.

Financial Policy:

- Co-pays, deductibles, and coinsurance amounts are due at the time of service.
- I am aware that as a courtesy, the practice does verify my insurance benefits prior to rendering service. It is ultimately my responsibility to know my insurance plan and the available providers in my network. The practice will not be responsible and will not appeal on my behalf if my insurance company failed to give them accurate networking information for my particular plan. Due to this, I have verified and am aware of how my network benefits apply to this practice prior to seeking treatment.
- If I do not have insurance or the physicians do not participate in my insurance plan, payment in full is expected at the time of my visit.
- Any unpaid balances or non-covered balances will by my responsibility.
- An account will be considered delinquent and referred to collections if a balance is more than 120 days past due and I have not made any payments or contacted the practice about financial hardship
- In the event that my account is referred to an attorney or agency for collections, I may be held responsible for reasonable attorney fees and court costs.
- Returned checks or declined credit charges will incur a $25 charge.
- I have noted the required 24-hour advance notice for appointment cancellations. There is a $50 charge if notice is not given 24 hours in advance or if I do not show up for my appointment. For canceling surgery, there is a $150 charge if 24-hour notice is not provided. I agree and understand that this rule is strictly enforced and non-disputable.

For billing questions, please contact the office at 832-232-4263 or email office@handandplasticskaty.com to speak with the billing specialist.

Patients Name: _____

Signers Name: _____ Date: _____

Signature required on page 9.

Communication Preferences

☐ **I wish to be contacted in the following manner** (Check all that apply):

☐ **HOME PHONE**:

☐ OK to leave a voice message with detailed information

☐ OK to leave a voice message with callback number only

☐ **CELL PHONE**:

☐ OK to leave a voice message with detailed information

☐ OK to leave a voice message with callback number only

☐ **EMAIL*****:

For billing or other written communication, please mail to:

Home address ☐ Work Address ☐ Other:

As per HIPAA- Your information cannot be shared with another individual without your prior consent. Please list any individuals you consent to sharing your medical and/or billing information with.

Multimedia Consent

☐ I hereby authorize the physicians of The Hand & Plastic Surgery Center of Katy and/or their associates or licensees to take pre-operative, intra-operative, and post-operative photographs or videos of myself. I understand that only medically pertinent material will be obtained as it relates to my health condition. I understand therefore that these images are for medical purposes only and are considered protected health information. I understand that these images may be used for educational or teaching purposes as well. All efforts will be made to ensure privacy is upheld. They will not be used for any marketing purposes without my prior written consent.

☐ I do not authorize the physicians of The Hand & Plastic Surgery Center of Katy and/or their associates or licensees to take pre-operative, intra-operative, and post-operative photographs or videos of myself.

_____

Patient Name

Signers Name:_____Date: _____

Signature required on page 9.

Notice of Patient Privacy Practices

Effective 2/1/2016

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.

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at The Hand & Plastic Surgery Center of Katy (referred to herein as *The Center*), a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, relevant photographs, and billing record. This record serves as a:

- Basis for planning your treatment and services
- Means of communication among the physicians and other health care providers involved in your care
- Means by which you or a third-party payor can verify that services billed were actually provided
- Source of information for public health officials
- Tool for assessing and continually working to improve the care rendered

This notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES

The Center shall:

- Make every effort to maintain the privacy of your medical information
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- *The Center* will notify you, and the Department of Health and Human Services of any unauthorized acquisition, access, use, or disclosure of your unsecured medical information that presents a significant risk of financial, reputational, or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow up care.
- **For Payment.** We will use and disclose your medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run *The Center* in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, *The Center* may provide a telephone, email, or text reminder that your next appointment with one of our physicians is coming up.

- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws and regulations.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety *OR* the health and safety of another person.

SPECIAL SITUATIONS

- **Workers' Compensation.** We may release medical information about you for workers' compensation or other similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include:
    - To prevent or control disease, injury, or disability
    - To report reaction to medications or problems with products
    - To notify people of recalls of products they may be using
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
    - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

  All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These include public and private agencies authorized to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- **Coroners, Medical Examiners, and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (e.g. to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Other Uses or Disclosures.** Any other use or disclosure of your Protected Health Information, unless required by law, will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy such information, you must submit your request in writing to *The Center*. If you request a copy of the information, *The Center* may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.
    - *The Center* may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by *The Center* will review your request and denial. The person conducting the review will not be the person who denied your request. *The Center* will comply with the outcome of the review.
- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask *The Center* to amend the information. To request an amendment, your request must be made in writing and submitted to *The Center*. In addition, you must provide the reason that supports your request. *The Center* may deny your request if you ask us to amend information that:

- Was not created by *The Center*, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the medical information kept by *The Center*
- Is not part of the information which you would be permitted to inspect and copy
- Is accurate and complete

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures". This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations. To request this list, you must submit your request in writing to *The Center*. Your request must state a time period, which may not be longer than 6 years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 month period will be free. For additional lists within the 12 month period, you may be charged for the cost of providing the list.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information *The Center* uses or discloses about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information *The Center* discloses about you to someone who is involved in your care of the payment of your care. *The Center* is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which *The Center* has been paid out of pocket in full. Should *The Center* agree to your request, *The Center* will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to *The Center*. In your request, you may indicate (1) what information you want to limit, (2) whether you want to limit *The Center's* use and/or disclosure, and (3) to whom you want the limits to apply.
- **Right to Request Confidential Information.** You have the right to request that *The Center* communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that *The Center* contact you only at work or by mail. To request that *The Center* communicate in a certain manner, you must make your request in writing. You do not have to state the reason for your request. The practice will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE

We reserve the right to change our practices and to make the new provisions effective for all Protected Health Information we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by the office.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with *The Center* or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with *The Center*, contact our office at 832-232-4263. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is: *Secretary of Health & Human Services*

Region VI, Office for Civil Rights
U.S. Department of Health & Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints shall be submitted in writing. **You will NOT be penalized for filing a complaint.**

By my signature, I acknowledge that I have read and understand the above information regarding the privacy of my protected health information. If the patient is a minor, the responsible party is required to sign below.

_____	_____	_____
Patient Name	**Personal Representative Name (If applicable)**	**Relationship to Patient**

Signature required on page 9.

Assignment of Benefits Form

I _____ (Print Name) with insurance benefits through (Employer Name if applicable) _____ (Medicare, Medicaid or Individual Plan) hereby authorize benefits to be assigned to the above listed healthcare provider, for healthcare services provided to me by the healthcare provider listed above. I hereby certify that the insurance information that I have provided the above listed healthcare provider is true and accurate as of the date of service and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of network services.

I hereby authorize Provider listed above to submit claims, on my behalf, to the insurance company providing benefits and payment provided to the above listed healthcare provider, in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full.

I hereby irrevocably designate, authorize and appoint Provider listed above as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered. This power of attorney shall automatically terminate, without formal action being taken, as soon as the above listed healthcare provider has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to patient. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

I hereby authorize my insurer to assign and transfer any and all applicable plan benefits and rights to Provider listed above and any appointed business associates working with them for the sole purpose of making sure all protected rights and entitled benefits under my specific plan are administered accurately, including the right to receive any applicable relevant plan documents/remedies, disclosures, pursue appeals, administrative reviews and litigation on my behalf. This authorization includes any and all other rights permissible under state and federal laws, as well as entitled plan programs. This is a direct assignment of my rights and benefits under this plan/policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment, at the determination of Plastic & Hand Surgeons of Katy. Upon receipt of said check, I authorize Provider listed above to receive any such checks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment on my account. This authorization includes any and all rights permissible including all rights of appeal, disclosures, administrative reviews, litigation on my behalf and remedies due under any Title XVIII of the Social Security Act, related provisions of Title XI as well as Federal, City or State Government program.

I hereby instruct and direct my Insurance Company to pay all entitled plan benefits at the stated plan benefit level directly to Provider listed above for all entitled benefits related to services rendered. I understand under applicable ERISA, state and/or federal regulatory guidelines that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my rights per state and federal ERSIA regulations hereby instruct and direct my Insurance Company to provide SPD documentation stating such non-assign ability clause to myself and Provider listed above. Upon proof of non-assign ability documentation, I then instruct that the insurer make out the check to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by the healthcare provider listed above will be immediately signed over and sent directly to Provider listed above.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, governmental agency or attorney involved in this case. I authorize Provider listed above or appointed business associates by the provider to be my personal representative, which allows them as my legally binding authorized representative to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my stated plan benefits based on billed charges, within ninety (90) days of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any penalties or fines levied against my insurance company will be paid to Provider listed above for acting as my personal representative.
I authorize the above provider to provide medical care reasonable and at the standard of care as required by state law.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Patients Name: _____

Signers Name: _____Date: _____

Signature required on page 9.

Notice of Patients' Rights and Responsibilities

Patient Rights

1. **Access to Care.** You will be provided with impartial access to treatment and services within this practice's capacity and availability in keeping with applicable laws and regulations. This is true regardless of race, creed, sex, national origin, religion, disability or handicap, or source of payment for care or services.
2. **Respect and dignity.** You have the right to considerate, respectful care and services at all times and under all circumstances. This includes recognition of the psychosocial, spiritual, and cultural variables that may influence the perception of your illness.
3. **Privacy and Confidentiality.** You have the right, within the law, to personal and informational privacy. This includes the right to:

- Be interviewed and examined in surroundings to ensure reasonable privacy
- Have a person of your own sex present during a physical examination or treatment
- Not remain disrobed any longer than is required for accomplishing treatment or services
- Expect that any discussion or consultation regarding care will be conducted discreetly
- Expect all written documentation pertaining to care to be treated as confidential

4. **Personal Safety.** You have the right to expect reasonable safety regarding the practice's procedures and environment.
5. **Identity.** You have the right to know the identity and professional status of any person providing services and which physician is primarily responsible for your care.
6. **Information.** You have the right to obtain complete and current information concerning your diagnosis (to the extend known), your treatment, and any known prognosis. This information should be communicated in terms that you can understand.
7. **Communication.** If you do not speak or understand the predominant language of the community, you should have access to an interpreter. This is particularly true when language barriers are a continuing problem.
8. **Consent.** You have the right to information that enable you, in collaboration with the physician, to make treatment decisions.

- Consent discussions will include an explanation of the condition, the risks and benefits of treatment, and the consequences of no treatment.
- Except in the case of incapacity or life-threatening emergency, you will not be subjected to any procedure unless you provide voluntary, written consent.

9. **Consultation.** You have the right to accept or refuse medical care to the extent permitted by law. However, if refusing treatment prevents the practice from providing appropriate care in accordance with ethical and professional standards, your relationship with this practice may be terminated upon reasonable notice.
10. **Charges.** Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed explanations of any billed services.

Patient Responsibilities

1. **Keep Us Accurately Informed.** You have the responsibility to provide, to the best of your knowledge, accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, substance use, and other matters relating to your health, including unexpected changes in your condition.
2. **Follow Your Treatment Plan.** You are responsible for following the treatment plan recommended by your physician. This may include following instructions of health care personnel as they carry out the coordinated plan of care, implement your physician's orders, and enforce the applicable practice rules and regulations.
3. **Keep Your Appointments.** You are responsible for keeping appointments and, when unable to do so for any reason, for notifying this practice in a timely manner.
4. **Take Responsibility for Non-Compliance.** You are responsible for your actions if you do not follow the physician's instructions. If you cannot follow through with the prescribed treatment plan, you are responsible for informing the physician.
5. **Be Responsible for Your Financial Obligations.** You are responsible for ensuring that the financial obligations of health care services are fulfilled as promptly as possible and for providing up-to-date insurance information.
6. **Be Considerate of Others.** You are responsible for being considerate of the rights of other patients and personnel and for assisting in the control of noise, smoking, and the number of visitors. You are also responsible for being respectful of practice property and property of other persons visiting the practice.
7. **Be Responsible for Lifestyle Choices.** Your health depends not just on the care provided at this facility but on the long-term decisions you make in daily life. You are responsible for recognizing the effects of these decisions on your health.

If there are any questions regarding the contents of this notice, please notify any staff member.

The Hand & Plastic Surgery Center of Katy

23960 Katy Freeway, Suite 380, Katy, TX 77494
Tel 832-232-4263 Fax 844-342-4263
www.handandplasticskaty.com

Patient Name:_____ Date of Birth:_____

Signers name:_____ Date_____

In order to save time at your first appointment, please fill out all pages and email back to **Office@HandAndPlasticsKaty.com** before arriving to your appointment. We will have you sign this acknowledgment page at check in. Otherwise, you can print out the packet, fill it out, and bring it in with you to your appointment.

By my signature below I acknowledge and affirm:

- I am legally authorized to sign for the patient listed above.
- All of the demographic information entered on page 1 is true to the best of my knowledge.
- I have read and understand the Practice Representation and Financial Policies on page 2.
- I agree to my selections on Communication Preferences and Multimedia Consent, and if I so choose to share my medical information I have my consent to share listed on page 3.
- I have read and been given a copy of the Notice of Patient Privacy Practices, pages 4-6.
- I acknowledge the Assignment of Benefits Form on page 7-8 and wish to have my insurance billed as listed.
- I have read and retained my copy of the Notice of Patients' Rights and Responsibilities on page 9.

X_____ Date:_____
Signature of Patient or Personal Representative

Please bring your insurance card and ID to your appointments. Patient insurance verification will be required.

If the patient is under the age of 18, they must be accompanied by a legal guardian at all appointments.