

**ADVANCED SURGICAL PHYSICIANS
ANDREW J. SHAPIRO, MD, PA**

1447 MEDICAL PARK BLVD, SUITE 407*WELLINGTON, FL 33414*PHONE: 561-333-1335*FAX: 561-333-4252

Updated September 2018

PRIVACY POLICY

It is the policy of our practice that all physicians and staff preserve the integrity and confidentiality of the protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice, its physicians, and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice, its physicians, and staff for the purposes of treatment, payment and healthcare operations (TPO). To that end, our practice, its physicians, and staff will -

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorization, as appropriate. Our practice, its physician, and staff will not use or disclose PHI for uses outside of practice's TPO, without authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice, its physicians, and staff will implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice, its physicians, and staff will respect the patient's individual dignity at all times. Our practice, its physicians, and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will –
 - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
 - Not disclose PHI data unless the patient (or his/her authorized representative) has properly authorized the release or the release is otherwise authorized by law.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes information is inaccurate or incomplete. Our practice and its physicians and staff will -
 - Permit patient's access to their medical records when their written requests are approved by our practice. If we deny the request, then we must inform the patient that he/she may request a review of the denial.
 - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
 - Provide patients with an electronic copy of the medical record upon your written request and approval by the practice. If we deny the request, then we must inform the patient that he/she may request a review of the denial.
- All physicians and staff will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as the request is in writing.
- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All physicians and staff must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of the policy is grounds for disciplinary sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon release of a revised privacy policy and will be made available to patients upon request.

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**PATIENT CONSENT OF USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

I hereby give authorization to Andrew J, Shapiro, MD, PA to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Andrew J. Shapiro, MD, PA's notice of Privacy Policy provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Policy prior to signing this consent. Andrew J, Shapiro, MD, PA reserves the right to revise the Notice of Privacy Policy at anytime. A revised Notice Privacy Policy may be obtained by forwarding a written request to Andrew J, Shapiro, MD, PA at 1447 Medical Park Blvd, Suite 407, Wellington, FL 33414.

With this consent, Andrew J, Shapiro, MD, PA, may call my home or other alternative location and leave a message on voicemail, with my spouse or myself in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Andrew J, Shapiro, MD, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. The practice is required to agree to my requested restrictions, if in writing.

Andrew J. Shapiro, MD, PA will not disclose or sell PHI for marketing purposes or use your information to raise funds without your prior authorization.

Andrew J. Shapiro, MD, PA will not disclose PHI to a health plan if you have paid for services in full out of pocket without your prior authorization.

If Andrew J. Shapiro, MD, PA decides, it is authorized to use automated appointment reminders by phone or text message, but you have the right to opt out of these types of communications by providing that notification in writing.

If Andrew J. Shapiro, MD, PA is notified or becomes aware of a breach in your PHI our staff will notify you in writing as soon as that breach has been discovered.

By signing the form, I am consenting to Andrew J, Shapiro, MD, PA's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Andrew J, Shapiro, MD, PA may decline to provide treatment to me.

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PATIENT FINANCIAL POLICY

Welcome to our practice! Our doctors are dedicated to providing the best possible surgical care and service to you. If you have any additional or specific questions, please contact our billing company. Our financial policy is:

- Unless you or your insurance company has made other arrangements, in advance, payment is due at the time of service. For your convenience, the office accepts cash, personal checks, credit cards, and debit cards.
- We are a participating provider for **Medicare**. You will be required to pay your Part B deductible unless your secondary insurance pays the deductible. You will be required to pay the 20% coinsurance unless your secondary insurance pays the coinsurance.
- If your physician is **NOT** a participating provider with your insurance company, we will file claims as a courtesy for you. Most insurance companies will send payment to the patient; therefore payment is due at time of service.
- If your physician **IS** a participating provider with your insurance company, we will file claims. You will be responsible for co-payments, coinsurance, and deductibles which are due at time of service.
- If your insurance company does not pay for services in a timely manner please understand that you will be held responsible for the entire amount of the submitted claim.

I hereby authorize the release of any information relating to claims for services that have been provided to me and/or dependents. I authorize Andrew J, Shapiro, MD, PA to submit claims for services that have been provided to me and/or dependents, without having to obtain my signature on each and every claim for myself and/or dependent. I authorize payment to be sent directly to Andrew J, Shapiro, MD, PA for services provided to me and/or dependents.

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Patient's Financial Responsibility Policy

Methods of Payment:

Acceptable methods of payment are cash, check (maximum \$250 unless paid 14 days prior), credit cards, and debit cards. Any check returned by your bank will incur a \$25.00 fee. If no insurance is on record, full payment is due at the time of service.

Payments and Balances:

- Copays, deductibles or coinsurances will be collected at check-in.
- Patients are responsible to know what their office visit responsibility is and to alert us of any change.
- Patients are responsible for surgical fees 24 hours prior to procedure. These fees may be paid over the telephone via credit card for your convenience.
- Past due balances are required in full prior to your next appointment.
- Credit Card refunds for **cancelled procedures** will be reduced by \$5.00 to cover processing fees incurred by the practice

Registration:

A fully completed, current patient registration will be on file in the patient chart during the time the patient is considered active.

Patient registration will be updated completely by the patient annually or upon any changes to maintain accurate information.

Social Security Numbers are required for each patient, including minors.

Signatures by the responsible parties are required.

Your insurance card will be photocopied annually or upon any changes. It is the patient's responsibility to keep us informed of any changes regarding the registration and insurance.

Accounts Past Due:

Payment of statement is due upon receipt.

Non-payment may result in preparation of account for collections bureau, small claims court and discharge from the practice. If any account goes unpaid for a period of more than 60 days, it may be turned over to an outside collection agency. The person financially responsible for the account will be responsible for all collection costs, reasonable attorney fees and all court costs. Any account sent to collections may result in the patient, and all family members that the patient is responsible for as guarantor being dismissed from the practice.

Insurance Claims:

You, the patient, or adult responsible party are responsible to know and understand your insurance coverage. This includes verification that our physicians are providers within your insurance network. It is your responsibility to make sure we have current insurance information.

Claim Submission:

In the event the patient has insurance coverage but cannot provide documentation, charges will be entered as self-pay. Upon submittal of insurance card, we will submit a health insurance claim form. Secondary insurance is filed upon patient's submission of proof of secondary insurance.

Referrals:

Certain insurances require that you have a referral from your primary care physician. Please make sure that your PCP has been notified of this appointment and has provided us and you with a copy of that referral prior to your appointment. If a referral is not received by the time of your appointment we will need to reschedule your visit for another time. Our practice will make every effort to help you acquire this referral, but it is ultimately the responsibility of the patient.

Account Consultation/Financial Assistance:

OUR PHYSICIANS DO NOT DISCUSS FINANCIAL ISSUES. OUR BILLING STAFF IS TRAINED TO DISCUSS YOUR ACCOUNT AND CAN MAKE PAYMENT ARRANGEMENTS IF NECESSARY.

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Office Policies

FORMS AND RELEASE OF RECORDS:

The completion of administrative forms about your care and duplication of medical records is not a part of your routine medical services from us. We are happy to assist you in any way we can, but we reserve the right to charge appropriately for these extra services based upon time and effort involved. The minimum fee is \$25.00 for the completion of administrative forms such as FMLA and disability claims. If you require us to copy your medical records, in accordance with the State Law, our policy is to charge \$1.00 per page for the first 25 pages, \$0.25 per page for pages 26 and higher plus postage. Additional charges may apply for records that are STAT and that need to be certified. You may pick-up the records for our office to save the postage fee. We can provide your records electronically downloaded to jump drive at no extra charge. Records requests can be made through the Patient Portal at no charge and are completed typically within 24 hours.

- Requests must be made in writing by filling out our records release form or emailing a request through the patient portal.
- There is no cost to provide records to facilities or physicians that we refer you to see.
- Please allow up to 10 business days for records to be available for pick up or delivery.
- Please allow up to 3 business days for FMLA and disability claims to be completed.

Patient Portal: We invite you to use our patient portal. It is available for access via our website advancedsurgicalphysicians.com or directly at myhealthrecord.com. Once you provide an email address to our office, you will be sent an email with instructions for activation. Once activated, we can provide you with access to appointment requests, clinician question requests, and availability to your lab work, pathology and operative reports after any required follow up appointments.

Results: It is the policy of our practice not to release results via mail, email, portal or telephone until the doctor reviews the results with you in person. When you are scheduled for any diagnostic testing, blood work, surgery/biopsy, or any in-office procedure, you must have a follow up appointment for results and continuation of care. It is your responsibility to make and keep all scheduled appointments for your follow-up care. If you cannot make an appointment it is your responsibility to reschedule that appointment.

Minors/Dependents:

Children under the age of 18 will require the signature of a responsible adult party on the registration form. We cannot treat an unaccompanied minor.

Cancellation Policy: As a courtesy to the practice and other patients we request 48 hour notice of cancellation of office appointments. Except for illness, we require one week notice of cancellation of any hospital or office surgical procedure. A fee may apply for cancellations not completed within the above time frame.

Use of Electronic Devices- Due to the sensitive nature of our practice we request that you limit the use of electronic devices while in the office. Please use appropriate headsets for streaming music, games and videos. Please step out of the office if you would like to take a phone call. Once you enter the exam room with the physician we request that your device be turned off. Unless a special request has been made and approved, there is no audio or video recordings of appointments permitted.

Refills of Medication: Narcotic pain medication cannot be called in over the telephone. You may be required to see the doctor before any medication can be refilled.

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.

HOW WE MAY USE AND DISCLOSE

HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health Information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations: We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services: We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities: We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law: We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation: We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Access to electronic records: The Health Information Technology for Economic and Clinical Health Act, HITECH Act allows people to ask for electronic copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy: You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend: If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request: If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form.

ANDREW J. SHAPIRO, M.D., P.A.
1447 MEDICAL PARK BLVD #407
WELLINGTON, FL 33414
561-333-1335

Update 9/13

Patient Printed Name: _____ Date of Birth: _____

Guarantee of Payment

PAYMENT GUARANTEE	I have been provided and had the opportunity to review the Patient Financial Responsibility and Patient Financial Policies.		
	Patient Signature: _____	Date: _____	
	Responsible Party Signature: _____	Relationship: _____	Date: _____

Consent to Medical and Surgical Treatment

Consent	The undersigned hereby consents to all medical care and services, surgical treatment, tests, and procedures, including, but not limited to radiological studies, laboratory and diagnostic procedures, and anesthesia, which a physician, their employees, nurses, or designees may deem advisable to the undersigned patient during this treatment.		
	Patient Signature: _____	Date: _____	
	Responsible Party Signature: _____	Relationship: _____	Date: _____
	If patient is under age 18, I hereby give my permission for _____ to be treated by Andrew J. Shapiro, MD, PA		

Assignment of Insurance Benefits

Assignment of Benefits	I hereby authorize payment directly to Andrew J. Shapiro, MD, PA, (AJSMDPA) and assign to them any and all rights and benefits that I or the patient may have under any policy of insurance including medical, automobile, personal injury protection, worker's compensation, or any other coverage further direct any such insurance company make payment of benefits directly to AJSMDPA. I understand that I am financially responsible to AJSMDPA. I understand that I am financially responsible to AJSMDPA for charges not covered by this assignment.		
	Lifetime Signature Authorization: I hereby authorize AJSMDPA to furnish to my insurance company or their representative, or Social Security Administration or the Center for Medicare and Medicaid, or Medigap or its intermediaries or to the billing agent of AJSMDPA any information needed for this claim or related claims. I permit a copy of this authorization to be used in place of the original.		
	Patient Signature: _____	Date: _____	
	Responsible Party Signature: _____	Relationship: _____	Date: _____

Notice of Privacy Policy

Privacy Policy	I have been provided and had the opportunity to review the Privacy Policy.		
	Patient Signature: _____	Date: _____	
	Responsible Party Signature: _____	Relationship: _____	Date: _____

Patient Consent of Use and Disclosure of Protected Health Information

Consent and Use of PHI	I hereby give authorization to Andrew J. Shapiro, MD, PA (AJSMDPA) to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (AJSMDPA's notice of Privacy Policy provides a more complete description of such uses and disclosures.)		
	I have the right to review the Notice of Privacy Policy prior to signing this consent. Andrew J. Shapiro, MD, PA reserves the right to revise the Notice of Privacy Policy at anytime. A revised Notice Privacy Policy may be obtained by forwarding a written request to Andrew J. Shapiro, MD, PA at 1447 Medical Park Blvd, Suite 407, Wellington, FL 33414.		
	With this consent, AJSMDPA, may call my home or other alternative location and leave a message on voicemail, with my spouse or myself in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.		
	With this consent, AJSMDPA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. The practice is required to agree to my requested restrictions, if in writing.		
By signing the form, I am consenting to Andrew J. Shapiro, MD, PA's use and disclosure of my PHI to carry out TPO.			
I may revoke my consent in writing except to the extent that the practice has already make disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, AJSMDPA may decline to provide treatment to me.			
Patient Signature: _____	Date: _____		
Responsible Party Signature: _____	Relationship: _____	Date: _____	

Notice Physician Financial Responsibility Coverage

Malpractice	I have been provided and had the opportunity to review the Notice Physician Financial Responsibility Coverage.		
	Patient Signature: _____	Date: _____	
	Responsible Party Signature: _____	Relationship: _____	Date: _____

Notice of Office Policies

Office Policies	I have been provided and had the opportunity to review the office policies regarding forms and release of records, availability of the patient portal, reporting results, cancellation policy, use of electronic devices, and refills of medication.		
	Patient Signature: _____	Date: _____	
	Responsible Party Signature: _____	Relationship: _____	Date: _____

E-mail Consent Form

Patient Name _____ Date _____

Patient E-mail address _____ Patient phone number _____

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

- a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
- b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
- c. E-mail senders can easily type in the wrong email address.
- d. E-mail is easier to falsify handwritten or signed documents.
- e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
- f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
- g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
- h. E-mail can be used to introduce viruses into the computer system.
- i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

- a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patients medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
- b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patients prior written consent, except as authorized or required by law.
- c. The patient is responsible for protecting his/her password or other means of access to e-

E-mail Consent Form

mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

- d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
- e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS:

To communicate by e-mail, the patient shall:

- a. Limit or avoid using his/her employer's computer.
- b. Inform Provider of changes in his/her e-mail address.
- c. Confirm that he/she has received and read the e-mail from the Provider.
- d. Put the patient's name in the body of the e-mail.
- e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).
- f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
- g. Withdraw consent only by e-mail or written communication to Provider.

4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

E-mail Consent Form

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Name (print) _____

Patient Signature _____ Date _____

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (print) _____

Patient Signature _____ Date _____

Notice of Privacy Acknowledgement

Advanced Surgical Physicians, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian (print)

Date

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

ADVANCED SURGICAL PHYSICIANS

Andrew J. Shapiro, MD, PA

1447 Medical Park Blvd. Suite 407

Wellington, FL 33414

Phone: 561-333-1335 Fax: 561-333-4252

Under Florida law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

Your doctor has decided not to carry medical malpractice insurance.

This is permitted under Florida Law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law.

*Patient Signature _____ Date _____

Print Name _____

****My signature acknowledges that I have read and understand the above notice.***