PROGRESSIVE SURGICAL CARE, PLLC
Dr. Marc E. Sher / Dr. T. Cristina Sardinha / Dr. Jonathan D.S. Klein / Dr. Alex Lee

PATIENT INFO:
(Please print)

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Cell #: _____ Email Address: _____

SS#: _____ Gender: _____ Marital Status: M S D W

Employer: _____ Employer's Address: _____

Spouse's Last Name: _____ Spouse's First Name: _____

PHYSICIAN REFERRAL INFORMATION:

Referring Physician: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION:
(Please provide your insurance card to copy)

Primary Insurance: _____ Policy ID #: _____

Insured's Last Name: _____ Insured's First Name: _____

Insured's Date of Birth: _____ Insured's SS #: _____

If your spouse is insured, or if you have secondary insurance, please provide us with that information:

2ND Insurance: _____ Policy ID #: _____

Relationship: _____ Date of Birth: _____

EMERGENCY/NEXT OF KIN CONTACT INFORMATION:

Last Name: _____ First Name: _____ Relationship: _____

Phone #: _____ Cell #: _____ Work #: _____

I authorize the Provider who rendered the services and all insurers and carriers to furnish any further information required.
I authorize payment of Plan Medical Benefits directly to the named Provider of Service.
I understand that I am responsible for any charges not covered by my Insurance Plan.

Signature: _____ Date: _____

HIPAA PRIVACY NOTICE

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.

INTRODUCTION:
Progressive Surgical Care, PLLC understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "Protected Health Information" (PHI). PHI includes any individually identifiable information that we obtain from you or others that relate to your past or future physical or mental health, the health care you received, or payment for your health care.

As required by law, this notice provides you with the information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain.

PERMITTED USES AND DISCLOSURES:
We can use or disclose your PHI for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use of disclosure in every category will be listed.

TREATMENT means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create an appropriate exercise regimen.

PAYMENT means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determination of eligibility and coverage, and utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third Party Payor about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payor for the services rendered to you, we can provide the Third Party Payor with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially protected health information for payment purposes and we will ask you to sign a release when necessary under applicable law.

HEALTH CARE OPERATIONS means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician review, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your PHI to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed and whether certain new treatments are effective. In addition, we may remove information that identifies you from your patient information so that others can use the de-identified information to study health care and health delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED INFORMATION:
In addition to using and disclosing your information for treatment, payment and health care operations, we may use your PHI in the following ways:

1) If a phone call is made to my home, I give permission to leave a message on my answering machine.
2) In addition, I give permission to disclose my PHI to the following person(s):

_____

I, _____, agree to the terms of this HIPAA Privacy Notice and acknowledge that I have been provided with a copy.

Date: _____ Signature: _____

Date of Birth: _____