American Surgical Arts, PC

"Exceptional experience . . .Extraordinary results"

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Board Certified Hand Surgeon

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PATIENTS' BILL OF RIGHTS

YOU have the right to respectful care, and to be treated respectfully.

YOU have the right to be informed about your diagnosis, to know what your treatment options are, and know what the potential outcomes of each treatment may be.

YOU have the right to know the names of those treating you.

YOU have the right to refuse treatment, permitted by law. You can refuse treatment and still receive alternative care.

YOU have the right to privacy. No medical practitioner should ever release information about your condition or treatment to anyone unless you give your express consent to release information.

YOU have a right to review your medical records, and if necessary have the information explained to you.

YOU have a right to know what alternative medical care may be available to you.

YOU have a right to know what your treatment may cost you.

YOU are responsible for providing all information about your past care, illnesses, and medications to your physician when he is trying to find the best possible treatment for you.

YOU are responsible for being considerate of the needs of others in the office.

YOU are responsible for providing all insurance information when requested, and following the requirements for your individual insurance plan for seeking treatment with the Doctor.

NOTICE OF PRIVACY PRACTICES/ HIPPA Form

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Please check both boxes if you have read and agree to the above policies. ☐ Patients' Bill of Rights ☐ HIPPA

_____ _____

Patient Signature Date