EMPIRE STATE
Colon & Rectal Surgery, LLC

Financial Policy

I authorize Empire State Colon & Rectal Surgery, LLC ("Empire") to release to the Social Security Administration and Centers for Medicare & Medicaid Services, its intermediaries or carriers, and to any other insurance or managed care company covering me or my dependents or insurance beneficiaries, any information, including protected health information, needed for processing of claims for payment for services rendered to me or my dependents or insurance beneficiaries, as applicable. I request that payment of Medicare, insurance or managed care benefits for services rendered to me (my dependents or insurance beneficiaries, as applicable), be made directly to Empire. If my insurance plan will not assign benefits to Empire, then I understand that I am responsible for payment of all charges, regardless of whether or not I am later reimbursed by my insurance plan. I understand that I am responsible for all deductable, co-payment and co-insurance amounts and for all non-covered services. I further understand and agree that if my insurance plan sends payment to me rather than Empire, I will immediately endorse the check to Empire and forward it to Empire to be cashed and applied to my account.

Health Information

I hereby consent and authorize Empire to use and disclose my health information, which includes all or any part of my medical records and any other information concerning my diagnosis or treatment, by and to its workforce members, health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of Empire.

I understand that, for example, my health information may be used or disclosed by Empire to: provide for my care and treatment, including the filling and supplying of prescriptions; communicate among various health care professionals who are involved in my care or treatment; obtain payment for care and treatment provided by Empire; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations.

I have read and understand Empire's HIPAA Notice of Privacy Practices, which is available in the office and contains information on the uses and disclosures of my protected health information. I understand that Empire has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, Empire will post a new notice in the office. I may contact Empire at any time to obtain a current copy of the HIPAA Notice of Privacy Practices.

I agree that Empire may disclose my protected health information to a family member, close personal friend, or other caregiver, who is involved with my healthcare and/or payment relating to my healthcare. In that case, Empire will disclose only information that is directly relevant to the person's involvement with my healthcare and/or payment relating to my healthcare unless I request otherwise. I agree that Empire may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist Empire in carrying out its business and healthcare operations including, but not limited to, appointment reminders, insurance items, any clinical care matters and laboratory results. Empire may also mail such information to my home or other designated locations.

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I understand that I have the right to object to the use and/or disclosure of my individually identifiable health information to family members.

PLEASE INITIAL NEXT TO THOSE APPLICABLE:

_____ I **consent** to the use of my individually identifiable health information (IIPI) ***as described on previous side*** for treatment, payment, and health care operations.

We respect your right to privacy regarding your medical information. We will NOT share your information with any family member, friend, significant other, or spouse without your written consent. If you would like to authorize us to share your information with someone, please list them below.

I **consent** to allowing the providers and staff of Empire to discuss my PHI with my family members, significant other, or my personal representative

NAME:_____**Relationship:**_____**Phone:**_____

NAME:_____**Relationship:**_____**Phone:**_____

OR

_____ I **restrict** the providers and staff of Empire from discussing my PHI with anyone other than myself.

I understand that I may revoke this consent in writing, but that revocation will not be affect to the extent that Empire has already taken action in reliance on my earlier effective consent.

_____
Patient Signature

_____
Print Patient's Name

_____
Date

1/5/15