NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____ _____

Name of Patient | Signature of Patient

_____ / _____ / _____

Date Signed

_____ _____

Name Patient's Personal Representative | Signature of Patient's Personal Representative

_____ / _____ / _____

Date Signed

FOR INTERNAL USE ONLY

_____ _____

Name of Employee | Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

☐ Patient was unable to sign.
☐ Patient refused to sign.
☐ Other _____

_____

____ - ____ (Version: As noted on NPP) ____/ ____/ ____ (Date: As noted on NPP)

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

PATIENT ID

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # _____ Mobile #_____

Work # _____ Other _____

Email Communication Preference

Email Address_____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Advanced Surgical Concepts, LLC, its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.
If an email address has been provided, Advanced Surgical Concepts, LLC, its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update Advanced Surgical Concepts, LLC when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

_____

Patient's Signature for consent to text message.

Mail Communication Preferences

May we send mail to your home address? YES NO **(If no, please provide an alternate mailing address below.)**

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information and/or financial information? (Check all that apply)

	Name:	**Telephone**
☐ Spouse	_____	_____
☐ Caretaker	_____	_____
☐ Child	_____	_____
☐ Parent	_____	_____
☐ Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**

ASC
Advanced Surgical Concepts

9118 Bluebonnet Centre Blvd., Baton Rouge, La 70809
Phone 225-368-2330 Fax 225-368-2275

Acknowledgement of Notice

I have received the following information prior to my procedure, both verbally and written in a language I understand, and have been given the opportunity to ask questions about it:

1. Patient Bill of Rights
2. Disclosure of Financial Interest
3. Advanced Directive Notice
4. Balance Billing Disclosure
5. Submission and Investigation of Grievances

_____ _____

Signature of patient or patient representative Date

_____ _____

Signature of Employee Date

Advanced Surgical Concepts
Phone: 225- 368-2330

Medication Reconciliation Record

* Form must be completed prior to case or case may be delayed

Please list your current medications			Post Op Instructions (To be filled out by surgery center staff)	
Name	Dosage	Directions	Resume Post Op	Other Instructions

Nurse giving instructions: _____ Date: _____

☐ No Known Allergies

Please list any allergies and the reaction	
Allergies	Reaction

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____