LUTZ SURGICAL PARTNERS

19105 N US Hwy 41, Suite 300
Lutz, FL 33549
Phone: 813-866-1959 Fax: 813-866-1957

PATIENT REGISTRATION

Reason For Visit: ____________________ Today's Date: ________________________

Type of Surgery: _____________________ Date of Surgery: ______________________

Name: ________________________________ Date of Birth: ________________________

Address: ____

City__________________________ State______________ Zip____________________

Home Phone: ________________________ Cell Phone: ____________________________

Social Security Number: ____

Sex: M___ F___ Single: ___ Married: ___ Widowed: ___ Divorced: ___ Separated: ____

Nearest Relative not living with you: __________________________ Phone: ____________

Notify in case of Emergency: ________________________ Phone: ____________________

Primary Insurance: ____

Subscriber Name: ________________________ Relation to patient: ___________________

Subscriber Date of Birth: _____________ Subscriber SS#:___________________________

Policy Number: ____________________ **Group Number:** _______________________

Secondary Insurance: ____

Subscriber Name: ________________________ Relation to patient: ___________________

Subscriber Date of Birth: _____________ Subscriber SS#:___________________________

Policy Number: ____________________ Group Number: __________________________

Patient's Employment: ______________________________ Bus. Phone: ______________

Person Responsible for Bill: _____________________________ Phone: _______________
Address: ____

Referring Physician: ____

Email: ____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, __________________________, understand that as part of my healthcare, Lutz Surgical Partners PLLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plan for future plan for treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided a Notice of Privacy Practices that provides more completed description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Lutz Surgical Partners PLLC is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance there on. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treatment as permitted be Section 164.506 of the Code of Federal Regulations.

I further understand that Lutz Surgical Partners PLLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Lutz Surgical Partners PLLC change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to use or disclosure of my health information:

____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

____________________________ ________________________

Patient Signature Date

Confidential Communications Request Form

I, ___________________________, request confidential communication of my health information when my health information is disclosed on my behalf.

Please use the following address or manner in disclosing my health information to me. Please list any and all people that we are allowed to release your medical information to.
____
____
____
____

Patient Signature: ________________________________ Date: ___________________

Policy for the Collection of Patient Deductibles, Coinsurance and Other Patient Balances

1. The Practice will never waive any coinsurance, deductible or other patient responsibility except for reasons of financial hardship as set forth in the attached Charity Care Policy.
2. The Practice will never waive a balanced bill, that is, the different between charge and payment for out of network patients of the Practice (hereinafter, "Balance Bill"), except for reasons of financial hardship as set forth in the attached Charity Care Policy.
3. The Practice shall immediately bill patients for any coinsurance, deductible or other patient responsibility upon receipt of an EOB or other correspondence from the payor that such coinsurance, deductible or other patient responsibility is payable by the patient.
4. The Practice shall bill patients for a Balanced Bill after the practice has received an EOB from the insurance carrier. In some cases, the Practice shall bill patients after the first level appeal for increased reimbursement is filed by the Practice.
5. Patients of the Practice shall sign for receipt of the Practice's Charity Care Plan, an Assignment of Benefits and Consent Form at the time services is first rendered by the Practice.
6. The Practice understands that both State and Federal law require that the patient be provided a Balanced Bill Statement.
7. The Practice will ensure that patient's understand that they are responsible for deductibles, coinsurance, the Balanced Bill and any other patient responsibility designated by the payer's EOB.
8. Patients must return claim checks sent to patient's within 10 days of receipt to avoid collections.

Patient Acknowledgement of the Practice's Policy for the Collection of Patient Deductibles, Coinsurance and Other Patient Balances

I, ________________________________ (**print patient's name**), hereby acknowledge that I have received and understand the Practice's Policy for the Collection of Patient Deductibles, Coinsurance and Other Patient Balances.

By: ____
Patient Signature (or Legal Guardian of Patient)

Acknowledged on: _____________________ (Date)

Authorization of Direct Payment, Power of Attorney Designation, Designation of Authorized Representative and/or Assignment Agreement

WHEREFORE, I am a participant or beneficiary **[circle one or the other]** of a health care benefit plan (the "Plan") provided by my employer
____ **[specify employer]**;

WHEREFORE, the Plan is administered and/or insured by ______________________
____________________________________ **[specify insurance company]** and other fiduciaries;

WHEREFORE, I am seeking health care services from __________________________
[specify healthcare provider or entity in whose name insurance claim will be submitted] ("Provider"), which I believe to be covered services under the Plan, and I may seek additional services from Provider in the future;

WHEREFORE, it is my intention to have any benefits owed to me by the Plan paid directly to Provider, and to give to Provider the right to bring -- on my behalf -- any and all legal or equitable claims that I have against the Plan and/or its fiduciaries relating in any way to benefits that are owed to me or may be owed to me in the future with respect to such services; and

WHEREFORE, it is also my intention, as an alternative basis for having benefits owed to me by the Plan paid directly to Provider and giving Provider the right to bring any and all legal or equitable claims that I have against the Plan and/or its fiduciaries relating in any way to benefits that are owed to me or may be owed to me in the future with respect to such services, to transfer, give, and assign my benefits under the Plan to Provider,

NOW, THEREFORE:

A. Patient Acknowledgement of Liability

I understand and acknowledge that I am liable for the full charges for the health care services that I receive from Provider and agree to pay all such charges that are not paid by my Plan. In exchange for Provider providing services to me now and in the future without requiring payment of these charges up front, and for Provider having agreed to submit claims for benefits to my Plan, and because Provider is in a better position to file such claims than I am, I hereby execute the following authorization, designations, and/or assignment.

B. Authorization to Receive My Benefit Payments

I authorize Provider to submit claims for Plan benefits (each, a "Benefit Claim") directly to the Plan and/or its fiduciaries and I authorize and direct the Plan and/or its fiduciaries to pay such benefits directly to Provider, and I hereby designate Provider as the person entitled to such benefits pursuant to ERISA, 29 U.S.C. § 1002(8), including all benefits owed now or in the future by the Plan for covered services provided by Provider;

C. Power of Attorney Designation

To the extent any dispute arises between Provider and my Plan and/or its fiduciaries relating to a Benefit Claim or the manner in which similar claims will be treated by the Plan and/or its fiduciaries now or in the future, it is my intention that the Plan and/or its fiduciaries give Provider on my behalf any and all rights to which I would otherwise be entitled, and I therefore appoint Provider as my true and lawful attorney-in-fact for the purpose of exercising the following powers on my behalf:

1. To do all acts necessary for the purpose of pursuing administrative appeals;

2. To do all acts necessary for the purpose of investigating, filing, pursuing, and resolving litigation on my behalf (including but not limited to selecting and retaining legal counsel) of any and all legal and equitable claims that I could bring against the Plan and/or its fiduciaries. Such legal and equitable claims shall include, but not be limited to, any and all claims (including breach of fiduciary duty claims) that I could bring pursuant to ERISA, 29 U.S.C. § § 1132(a)(1), (a)(2) or (a)(3), other provisions of ERISA that grant me a cause of action, other federal or state statutes, or the common law, and shall include class claims in which Provider serves as a class representative (hereinafter, collectively, "Causes of Action"). If Provider brings such an action, I agree to be bound by a final determination of such action rendered by a court or regulatory proceeding.

3. To sign on my behalf settlement agreements, releases, or other documents relating to the settlement of the Causes of Action. I hereby agree to be bound by any settlement, compromise or release reached by Provider on my behalf and that any document executed in connection with any such settlement, compromise or release by Provider on my behalf shall be binding on me.

4. To claim on my behalf any benefits, reimbursements, damages, surcharges, or any other applicable remedy, including fines or injunctive relief, to which I am entitled in connection with the Causes of Action.

5. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

D. Designation of Authorized Representative

To the extent the Power of Attorney designation described in Section C above is deemed ineffective for any reason, I hereby designate Provider as my Authorized Representative as provided under ERISA, 29 C.F.R. § 2560.5031(b)(4), for purposes of exercising the powers described in Section B or authorized under law, whichever powers are greater.

E. Assignment of Benefits and Legal Rights

To the extent or in the event that any power(s) and/or rights conveyed by Sections B, C, or D are deemed ineffective or limited for any reason or in any way, I hereby transfer, give, assign, and otherwise convey to Provider, for good and valuable consideration, the receipt and sufficiency of which are hereby expressly acknowledged: (a) all of my right, title, and interest in benefits under the Plan for the covered services I received, and (b) all legal and equitable rights that I have as a Plan participant or beneficiary, including but not limited to all rights to: (i) submit a Benefit Claim directly to the Plan and/or its fiduciaries; (ii) receive all benefits otherwise due me under the Plan for covered services; and (iii) bring any Cause of Action against the Plan or any of its fiduciaries to obtain such benefits, to enforce the fiduciary duties owed to me by the Plan and/or its fiduciaries, or to obtain any other appropriate legal or equitable relief available under the Cause of Action.

F. Acknowledgements

By signing this form, I understand that Provider is not assuming any obligation or duty to assert the rights conveyed herein, and I agree to release any claim I might have relating to Provider's exercise of such rights or the decision not to exercise such rights.

If Provider initiates a lawsuit against me to collect any unpaid balance owed for services provided to me, all the rights and powers conveyed herein shall be rescinded and I retain any claims or defenses I otherwise may have against Provider.

A photocopy of this Agreement shall be as effective and valid as the original.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

________________________________	________________________
Patient	Insurance Identification Number
________________________________	________________________
Signature	Date
________________________________	________________________
Policyholder/Insured	Insurance Identification Number
________________________________	________________________
Signature	Date