ISLAND SURGICAL CENTER
171 Farenholt Avenue
Tamuning, GU 96913
Telephone: 671-646-0443/4

FOR OFFICE USE ONLY

Dialysis @: US Renal: TAM ____ SIN ____ HAR ____
Tumon Kidney Center ____
Days: M ____ T ____ W ____ Th ____ F ____ S ____
Time: _____

REGISTRATION

Sex: ____ Male ____ Female Age: _____
____ Single ____ Married ____ Widowed ____ Divorced

Date _____

Patient name _____ _____
Last Name, First Name, Initial Patient Social Security #

Birthdate _____ Telephone: (H)_____ (W) _____ (C) _____

Responsible Party (If a minor) _____ Relationship: _____

Mailing Address _____
Post Office Box or Street Address City, State, Zip Code

Patient Employed By _____ Occupation _____

Business Address _____ Phone _____

Emergency Contact: _____ Relationship: _____ Phone _____

Who is your Primary Care Physician? _____ Who is your Referring Physician? _____

DO YOU HAVE MEDICAL INSURANCE? YES ____ NO ____ IF YES,

Primary Insurance Name _____ Subscriber # _____

Subscriber's Name _____ Subscriber's SSN # _____

Relationship to Patient _____ Subscriber's Birthdate _____

Secondary Insurance Name _____ Subscriber # _____

Subscriber's Name _____ Subscriber's SS # _____

Relationship to Patient _____ Subscriber's Birthdate _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

X_____ _____
Signature of Insured / Guardian **Date**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

X_____ _____
Signature of Insured / Guardian **Date**

171 Farenholt Avenue
Tamuning, Guam 96913
Tel: 646.0443 646.0444
Fax: 646.0440

PATIENT NO CALL, NO SHOW AGREEMENT

To our Valued Patients:

We have been experiencing a significant amount of broken appointments or short notice of cancellations. **A fee of $50.00 will be imposed for appointments missed or cancelled without 24-hour notice. A fee of $100.00 will be imposed for procedures missed or cancelled without 24-hour notice** and must be paid in order to make another appointment.

Please help Island Surgical Center Staff plan your care by notifying the office at least one day in advance if you need to reschedule your appointment.

Please note that this policy was designed as a courtesy for other patients awaiting an appointment or procedure date and time.

Thank you for your understanding.

Acknowledged by: _____

Print Name & Date

_____

Patient Signature

_____ _____

Island Surgical Center Staff Date

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OUTPATIENT TERMS AND CONDITIONS

1. AUTHORIZATION FOR TREATMENT: I hereby consent to and authorize any procedures or treatments necessary to my healthcare as advisable in the judgement of the physician in charge. I understand that these procedures or treatments will be fully discussed with and explained to me.

2. RELEASE OF INFORMATION: I hereby authorize Island Surgical center to disclose all or any part of my medical record to any person or corporation which is or may be liable under a contract to Island Surgical Center or to myself or to my family members or employer for all or part of the doctor's charge, including, but not limited to hospital of medical service companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer. Island Surgical Center will honor any specific authorization of any part of my medical records. I understand that I will have to submit this request in writing, and it shall be effective until such time that I revoke request in writing.

3. ASSIGNMENT OF INSURANCE BENEFITS: Should the undersigned be entitled to medical benefits of any type whatsoever arising out of any policy of insuring patient or any other party liable to patient, these benefits are hereby assigned to Island Surgical Center for application on the patient's bill.

4. FINANCIAL AGREEMENT: The undersigned agrees whether he signs as agent of patient that in consideration of the services rendered to the patient, he hereby individually obligates himself to pay to Island Surgical Center, within thirty (30) days of the bill date any portion not covered by his or her insurance (s).

THE UNDERSIGNED agrees that any amount not paid in accordance with the above financial agreement shall be considered past due.

THE UNDERSIGNED certifies that he/she has read the foregoing and is the patient or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

ISC Chart Number: _____ **Insurance:** _____

_____ _____
Signature of Patient **Signature of Patient's Guarantor**

_____ _____
Print Patient Name **Print Guarantor Name**

_____ _____
Date **Date**

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only.

☐ Written Communication
☐ O.K. to mail to my home address
☐ O.K. to mail to my work/office address
☐ O.K. to fax to this number _____

☐ Work Telephone _____
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only.

☐ Other _____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information.

I, _____ (Patient name), authorize the following person(s) to pick-up my Medical Records.

____ (Pt initials or authorized party)

****Authorization remains valid one year from authoization date below.**

Authorization Date	Enter Name	Contact #	Relationship to patient

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Commitment to you Privacy

ISC is committed to maintaining the privacy of your **Protected Health information** or **PHI**. ISC will create records regarding the treatment and services they provide to you.

ISC is required by law to:

- Keep your medical information private
- Provide you this notice describing their legal duties, privacy practices and your rights regarding your medical information
- Follow the terms of the notice that is now in effect

ISC has the right to:

- Revise or amend this notice at any time, provided these changes are permitted by law
- Make changes in their privacy practices and the new terms of the notice effective for all medical information that they keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices

Before ISC makes an important change in their privacy practices, they will change this notice and make the new notice available upon request.

Different ways ISC may use and disclose your Medical Information

TREATMENT: ISC may use your PHI to provide you with medical treatment or services. They may disclose your PHI to other healthcare providers for purposes related to your treatment.

PAYMENT: ISC may use and disclose your PHI for payment purposes.

HEALTH CARE OPERATIONS: ISC may use your PHI for health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and obtaining grants.

HEALTH RELATED BENEFITS AND SERVICES: ISC may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

DISCLOSURE REQUIRED BY LAW: ISC will use and disclose your PHI when required to do so by federal, state, and local law.

HEALTH OVERSIGHT ACTIVITIES: ISC may disclose your PHI to a health oversight agency for activities authorized by law. This includes investigations, inspections, audits, licensure, and disciplinary actions.

LAWSUITS: ISC may use and disclose your PHI in response to administrative or court order.

LAW ENFORCEMENT: ISC may release your PHI if asked to do so by law enforcement officials.

SERIOUS THREATS TO HEALTH OR SAFETY: ISC may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another person.

MILITARY: ISC may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

NATIONAL SECURITY: ISC may disclose your PHI to federal officials for intelligence and national security activities.

INMATES: ISC may disclose your PHI to correctional institutions of law enforcement officials if you are an inmate or under custody of law enforcements.

WORKER'S COMPENSATION: ISC may release your PHI for worker's compensation.

Notice of Privacy Practices

PUBLIC HEALTH RISKS: Your PHI may be used to maintain vital records; reporting child abuse or neglect; preventing or controlling disease, injury or disability; notifying a person regarding potential exposure to a communicable disease; notifying a person regarding potential risk for spreading or contracting a disease or condition; reporting reactions to drugs or problems with products of devices; and other public health risks.

Your Individual Rights

CONFIDENTIAL COMMUNICATION: You have the right to request that ISC communicate with you about your PHI by different means or to different locations. For instance, contacting you at home rather than at work. Your request must be in writing.

PLACING RESTRICTIONS: You have the right to request that ISC place additional restrictions in the use or disclosure of your PHI.

INSPECTION AND COPIES: You have the right to inspect and obtain a copy of your PHI. Your request must be done in writing.

LISTING: You have the right to request a list of all the times ISC has shared your PHI for Purposes other than treatment, payment, health care operations, and other specific exceptions.

AMENDMENTS: You have the right to request that your PHI be changed. ISC may deny your request if they did not create the information you want changed, you did not submit the request in writing or the reason supporting your request. If ISC denies your request, they will provide you a written explanation. You may respond with a statement or disagreement that will be added to the information you wanted changed. If ISC accepts your request to change the information, ISC will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

ACCOUNT DISCLOSURE: You may request for an account disclosure which is a list of certain non-routine disclosures not related to treatment, payment, or operations. All written requests must state a time period, which may not be longer than six years from the date of disclosure and may not include dated before April 4, 2003.

PAPER COPY: You are entitled to receive a paper copy of the *Notice of Privacy Practices*. You may ask at any time for a copy.

RIGHT TO FILE A COMPLAINT: If you believe your privacy rights have been violated, you may file a complaint with ISC or with the Secretary of the Department of Health and Human Services.

RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES: ISC will obtain your written authorization for uses and disclosures that are not identified by the *Notice*. Any authorization you provide to use regarding the use and disclosure of your PHI may be revoked at any time.

Patient Name

Date

X

Patient Signature