Barrington
Ambulatory Surgery Center™

Patient Information

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Mobile Phone #: _____

Email: _____ Marital Status: _____

Employer Name: _____ Work Phone: _____

Insurance Information

Primary Insurance: _____ Name of Insured: _____

Member ID: _____ Member DOB: _____ Group Number: _____

If Applicable

Secondary Insurance: _____ Name of Insured: _____

Member ID: _____ Member DOB: _____ Group Number: _____

Assignment of Benefits and Authorization Agreement

In consideration of the medical expenses incurred, I, the undersigned, hereby acknowledge that I have insurance and/or employee health care benefits coverage as detailed above. I assign and convey directly to *Barrington Ambulatory Surgery Center* all medical benefits and/or insurance reimbursements, if applicable, otherwise payable to me for services rendered by the doctor and facility.

I understand and agree that I am financially responsible for all charges, regardless of any applicable insurance or benefit payments.

I hereby authorize the doctor to:

1. Release all necessary medical information required to process this claim.
2. Obtain, upon written request, any plan documents, insurance policies, and/or settlement information from any plan administrator, fiduciary, insurer, or attorney in order to secure such benefits or reimbursements.

Additionally, I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

Conveyance of Rights

I hereby assign to the named doctor and facility, to the fullest extent permissible by law and under any applicable insurance policies or employee health care plans, any claim, right, or cause of action I may have for insurance or health care benefits for medical expenses incurred. This assignment includes, but is not limited to, the right to pursue medical benefits, insurance reimbursements, and any applicable remedies.

In response to any reasonable request, I agree to cooperate with the doctor and facility in pursuing claims, rights, or legal actions against insurers or employee health care plans. If necessary, I authorize the doctor and facility to initiate legal proceedings in my name, at their expense, to pursue such claims or rights.

Anti-Assignment Provision

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

Term and Validity

This assignment shall remain in effect until I revoke it in writing. A photocopy of this agreement is as valid as the original.

I have read and fully understand the terms of this agreement.

Signature: _____ **Date:** _____

Barrington
Ambulatory Surgery Center™

Patient Acknowledgment and Financial Policy Agreement

We appreciate you being a patient at our practice. We are committed to providing you with the highest level of quality care. As part of our dedication to ensuring your safety and convenience, our Ambulatory Surgery Center adheres to strict guidelines to demonstrate our commitment to quality patient care.

To enhance your experience and safety, we offer our own surgical facility suite for procedures, eliminating the need to send you to a hospital. Below is important information regarding the billing process and your responsibilities:

Billing Process and Explanation of Benefits (EOBs):

1. For your procedure, you will receive three Explanation of Benefits (EOBs) from your insurance company. These are **NOT bills** but serve to explain the benefits paid and allowed by your insurance. The EOBs will cover:
    - **Physician services**
    - **Ambulatory surgical facility (BarringtonAmbulatory Surgery Center)**
    - **Anesthesia services (Pinnacle Anesthesia Ltd.)**
2. The **facility fee** includes the utilization of the operating/procedure room, recovery room, medical surgical supplies, and all equipment used.
3. Please note that while your physician may be in-network with your insurance, Barrington Ambulatory Surgery Center may not be. As a result:
    - Payments for the facility may be sent to you directly by your insurance company.
    - If this occurs, we request that you contact Barrington Ambulatory Surgery Center billing service at (847) 865-8684 immediately and forward the payment to ensure proper processing.

Billing Services Assistance:

- Our practice is committed to ensuring that no patient is denied the care they need in our facility.
- Our billing service may contact you to expedite payment for your procedure.
- They work diligently with your insurance carrier and may require your assistance regarding your insurance claim.

For any questions about your insurance coverage, please contact:

- **Barrington Ambulatory Surgery Center billing service:** (847) 865-8684 (Facility bill inquiries)
- **Pinnacle Anesthesia, Ltd. billing service:** (847) 865-8684 (Anesthesia bill inquiries)

Acknowledgment of Understanding: I acknowledge that I have read and understand the above information. I agree to comply with the outlined policies and procedures related to billing and payment.

Print Name: _____

Patient Signature: _____ **Date:** _____

Thank you for trusting us with your care. Your health and pain relief are our top priorities.

Barrington
Ambulatory Surgery Center™

Communications Waiver

Hereby Barrington Ambulatory Surgery Center to keep communication regarding my health information confidential by adhering to the following communication requests:

Phone number: (_____) _____-_____ [ ] Home [ ] Work [ ] Cell **Okay to leave voicemail?** [ ] Yes [ ] No

Phone number: (_____) _____-_____ [ ] Home [ ] Work [ ] Cell **Okay to leave voicemail?** [ ] Yes [ ] No

Emergency Contact

In case of emergency, please provide the name of a contact we may call to provide your medical information:

Contact Name: _____Relationship:_____

Phone number: (_____) _____-_____ [ ] Home [ ] Work [ ] Cell **Okay to leave voicemail?** [ ] Yes [ ] No

Other Authorized Personnel:

You can leave a message or medical information with the following people:

Contact Name: _____Relationship:_____

Phone number: (_____) _____-_____ [ ] Home [ ] Work [ ] Cell **Okay to leave voicemail?** [ ] Yes [ ] No

Contact Name: _____Relationship:_____

Phone number: (_____) _____-_____ [ ] Home [ ] Work [ ] Cell **Okay to leave voicemail?** [ ] Yes [ ] No

Print Name: _____

Patient Signature: _____**Date:** _____

HIPAA NOTICE OF PRIVACY PRACTICES ("NOTICE")

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT FURTHER DETAILS HOW YOU OR YOUR PERSONAL REPRESENTATIVE MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice describes how our practice, along with our health care professionals, employees, volunteers, trainees, and staff, may use and disclose your medical information to carry out treatment, payment, or health care operations, and for other purposes outlined in this Notice. We understand that medical information about you is personal and are committed to safeguarding it. This Notice applies to all records of your care generated by our practice.

This Notice also details your right to access and control your medical information. The information about you includes demographic details that may identify you and relate to your past, present, and future physical or mental health or condition and related health care services. Typically, this medical information will include symptoms, examination and test results, diagnoses, treatments, and plans for future care.

We are required by law to protect the privacy of your medical information and to follow the terms of this Notice. We may change the terms of this Notice at any time. The new Notice will apply to all medical information we maintain, both current and in the future. If you request, we will provide you with a revised copy, either by mail or in-person at our office.

1. Uses and Disclosures of Protected Health Information Your medical information may be used and disclosed for purposes of treatment, payment, and health care operations. Below are examples of how we use and disclose your medical information.

a. Treatment: We may use and disclose medical information about you to provide, coordinate, or manage your medical treatment or any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your medical information. For example, we could disclose your medical information to a home health agency that provides care to you. We may also disclose medical information to other physicians who may be treating you, such as a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your medical information to another physician or health care provider, such as a laboratory.

b. Payment: We may use and disclose medical information about you to obtain payment for the treatment and services you receive from us. For example, we may need to provide your health insurance plan information about your treatment plan so that they can make a determination of eligibility or to obtain prior approval for planned treatment, such as disclosing relevant medical information to the health plan to obtain approval for hospital admission

c. Healthcare Operations: We may use or disclose medical information about you in order to support the business activities of our practice. These activities include, but are not limited to, reviewing our treatment of you, employee performance reviews, training of medical students, licensing, marketing and fundraising activities and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your medical information to remind you of your next appointment. We may share your medical information with third party “business associates” that perform activities on our behalf, such as billing or transcription for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, we will have a written contract that contains terms that asks the “business associate” to protect the privacy of your medical information. We may use or disclose your medical information to provide you with information about treatment alternatives, case management or other health-related benefits and services that may be of interest to you. We may also use and disclose your medical information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, or a prescription refill reminder may be sent to you for a prescription you are currently prescribed or its generic equivalent. We may also send you information about products or services that we believe may be beneficial to you. You may contact **our Privacy Contact** to request that these materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our **Privacy Contact** to request that these fundraising materials not be sent to you.

d. Health Information Exchange (HIE): We, along with certain other health care providers and practice groups in the area, may participate in a health information exchange ("Exchange"). An Exchange facilitates electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers that participate in the Exchange. Through the Exchange, we may electronically disclose demographic, medical, billing and other health-related information about you to other health care providers that participate in the Exchange and request such information for purposes of facilitating or providing treatment, payment or health care operations.

2. Other Permitted and Required Uses and Disclosures We may use or disclose your medical information with your consent or authorization in the following instances, where you have the opportunity to agree or object to such use or disclosure. If you are unable to agree or object, your physician will use professional judgment to determine if disclosure is in your best interest.

a. Others Involved in Your Healthcare: We may disclose your medical information to a family member, relative, or close friend if it directly relates to their involvement in your healthcare. If you cannot agree or object, we may disclose this information based on our professional judgment that it is in your best interest.

b. Emergencies: We may disclose your medical information for emergency treatment. If we are unable to obtain your consent at the time of treatment, we will attempt to get your consent as soon as reasonably possible afterward.

c. Communication Barriers: If we attempt to obtain your consent but are unable to due to substantial communication barriers, we may disclose your medical information based on the reasonable assumption that you intended to consent.

3. Without Your Consent, Authorization, or Opportunity to Object In certain situations, we may use or disclose your medical information without your consent or authorization:

a. Required by Law: We may disclose your information when required by federal, state, or local law.

b. Public Health: We may disclose your information to public health authorities for controlling disease, injury, or disability.

c. Communicable Diseases: If authorized by law, we may disclose information to individuals at risk of contracting or spreading a communicable disease.

d. Health Oversight: We may disclose your information to health oversight agencies for audits, investigations, inspections, and licensure purposes.

e. Abuse or Neglect: If we believe you are a victim of abuse, neglect, or domestic violence, we may disclose your information to the appropriate authorities.

f. Food and Drug Administration (FDA): We may disclose your information to the FDA for adverse event reporting, product defects, or post-marketing surveillance.

g. Legal Proceedings: We may disclose your information in response to a court order, administrative tribunal request, or other legal processes.

h. Law Enforcement: We may disclose medical information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (i) responding to a court order, subpoena, warrant, summons or otherwise required by law; (ii) identifying or locating a suspect, fugitive, material witness or missing person; (iii) pertaining to victims of a crime; (iv) suspecting that death has occurred as a result of criminal conduct; (v) in the event that a crime occurs on the premises of the practice; and responding to a medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

i. Coroners, Funeral Directors, and Organ Donors: We may disclose medical information to a coroner or medical examiner for identification purposes, to determine the cause of death, or to allow them to perform other duties authorized by law. We may also disclose medical information to funeral directors as necessary to carry out their duties.

j. Research: We may use and disclose your medical information for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board ("IRB") or

Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate, written assurances that the PHI will not be re- used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

k. Criminal Activity: In compliance with federal and state laws, we may disclose your medical information if we believe it is necessary to prevent or lessen a serious and imminent threat to health or safety. We may also disclose information to law enforcement authorities if necessary for the identification or apprehension of a suspect.

l. Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations involved in organ procurement, transplantation, or tissue donation, as necessary to facilitate organ or tissue donation.

m. Military Activity and National Security: If you are a member of the armed forces, we may use or disclose medical information, (i) as required by military command authorities; (ii) for the purpose of determining by the Department of Veterans Affairs of your eligibility for benefits; or (iii) for foreign military personnel to the appropriate foreign military authority. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities, including for the protective services to the President or others legally authorized.

n. Workers' Compensation: We may disclose your medical information as authorized to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illnesses.

o. Inmates: We may use or disclose your medical information if you are an inmate in a correctional facility and our practice created or received your health information in the course of providing care.

p. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with health privacy regulations.

4. Statement of Your Rights with Respect to Your Medical Information This document briefly outlines your rights regarding your medical information and describes how you can exercise these rights.

a. Right to Inspect and Copy Your Medical Information: You have the right to inspect and obtain a copy of your medical information that originated in our practice. We may charge a reasonable fee for copying and mailing your records. If we maintain any portion of your Protected Health Information (PHI) in an electronic format, you have the right to receive this information from us in electronic format. We will charge no more than the actual labor cost to provide electronic versions of your PHI.
To request access to your medical records, send a written request to our Privacy Contact at: 600 Hart Rd., Ste. 300, Barrington, IL 60010 or fax (847)842-3708.
We will process your request within 30 days. If we deny your request, you will receive a written explanation of the denial. Note that you may not have the right to inspect or copy psychotherapy notes. In some cases, you may request a review of the denial decision. If you have questions, please contact our Privacy Contact.

b. Right to Request a Restriction of Your Medical Information: You may request that we not use or disclose part of your medical information for treatment, payment, or healthcare operations. You can also request that we not disclose specific information to family members or friends involved in your care or for notification purposes as described in this Notice.
To request a restriction, you must: State the specific restriction in writing and specify to whom you want the restriction to apply. You also have the right to restrict information sent to your health plan or insurer for services you paid for entirely out-of-pocket, with no claim made to your health plan or insurer.

c. Limitations on Our Ability to Agree to Restrictions: We are not required to agree to your request for restrictions. If we believe that allowing use and disclosure of your medical information is in your best interest, we may not grant your request. However, we must agree to a restriction if the disclosure is for payment or healthcare operations purposes and is not otherwise required by law or the information pertains to healthcare items or services for which you have paid in full and not through your health plan. If we agree to a restriction, we will not use or disclose your medical information in violation of that restriction,

except in emergencies.

d. Right to Request Confidential Communications: You have the right to request that we send confidential communications to a location other than your primary address. We will make reasonable efforts to accommodate these requests. Please submit your request in writing to our Privacy Contact.

e. Amendment of Medical Information: If you believe that any of the medical information we have about you is incorrect or incomplete, you may request an amendment. To make this request, please contact our Privacy Contact in writing and request our "Request to Amend Health Information" form. In certain cases, we may deny your request. If we do so, you have the right to file a statement of disagreement with us.

f. Accounting of Disclosures: This applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, family members or friends involved in your care, or for notification purposes. To receive information regarding disclosures made for a specific time period no longer than six (6) years please submit your request in writing to our Privacy Contact. We will notify you in writing of the cost involved in preparing this list. To the extent we maintain your PHI in electronic format, you may request an accounting of all electronic disclosures of your PHI for treatment, payment, or healthcare operations for the preceding three (3) years prior to such request.

g. Uses and Disclosures Based on Written Authorization: We will not use or disclose your medical information for purposes not covered by this Notice or required by law without your written authorization. Examples of such disclosures requiring your authorization include; most uses and disclosures of psychotherapy notes, uses for marketing purposes, unless specific conditions are met (e.g., face-to-face communication, nominal value gifts, certain prescription refill reminders, etc.), & disclosures that involve the sale of PHI. You may revoke your authorization at any time, except where we have already relied on it to take action.

h. Notification of Breach: You have the right to be notified if we (or our Business Associate) discover a breach of your unsecured protected health information.

i. Complaints: If you believe your privacy rights have been violated, you can file a complaint with us or the Secretary of Health and Human Services. To file a complaint with us, obtain a Complaint Form from our Privacy Contact. All complaints must be in writing. **Note:** We will not retaliate against you for filing a complaint.

Contact Information

To contact us regarding privacy concerns, please reach out to:

Barrington Ambulatory Surgery Center
Attn: Privacy/Compliance Officer
600 Hart Road, Suite 300
Barrington, Illinois 60010
Phone: 847-810-2000
Fax: 847-842-3708

Acknowledgment

By signing below, you acknowledge that you have received this Notice of Privacy Practices and had the opportunity to ask questions related to its content.

Print Name: _____

Patient Signature: _____ **Date:** _____

Barrington Ambulatory Surgery Center™

Patient's Rights

1. **Right to Considerate and Respectful Care:** You have the right to care that is considerate and respectful of your needs.
2. **Right to Privacy:** You are entitled to every consideration of your privacy concerning your medical care. Discussions, consultations, exams, and treatments should be conducted discreetly. Those not directly involved in your care must have your consent to be present.
3. **Right to Information about Your Care:** You have the right to obtain clear and current information from your physician about your diagnosis, treatment, and prognosis. If providing this information to you is medically inadvisable, it will be made available to an appropriate person on your behalf. You have the right to know the name of the physician coordinating your care.
4. **Right to Informed Consent:** You have the right to receive all necessary information to give informed consent before any procedure or treatment. This includes understanding the procedure, the medically significant risks, and the expected duration of recovery. You also have the right to know the name of the person performing the procedure.
5. **Right to Confidentiality:** All communications and records regarding your care should be treated as confidential, unless required by law.
6. **Right to Reasonable Access to Services:** The surgery center will make a reasonable response to your requests for services, providing evaluation, treatment, or referral as necessary. You may be transferred to another facility if medically required, but only after receiving full information about the need for and alternatives to such a transfer.
7. **Right to Know About Professional Relationships:** You have the right to know about any relationships between the surgery center and other healthcare or educational institutions. Additionally, you have the right to know about any professional or financial interests among those treating you. Dr. Chadi Yaacoub has ownership interests in this facility.
8. **Right to Refuse Human Experimentation:** You will be informed if the surgery center proposes any human experimentation affecting your care, and you have the right to refuse participation in such research.
9. **Right to Continuity of Care:** You are entitled to expect reasonable continuity of care, including knowledge about available appointment times and physicians. You will be informed of your continuing healthcare requirements following discharge.
10. **Right to Examine Your Bill:** You have the right to examine and receive an explanation of your bill, regardless of the source of payment.
11. **Right to Know the Center's Rules:** You have the right to be informed about any rules or regulations at the surgery center that apply to your conduct.
12. **Right to File Complaints:** You or your representative have the right to be informed of the complaint process. Concerns about your care or safety should be reported. You may contact the nurse manager or the Illinois Department of Public Health (1-800-252-4343) or Joint Commission (800-994-6610) for assistance.
13. **Right to Advance Directives:** You have the right to an advance directive, such as a living will or healthcare proxy. However, this facility does not honor advance directives. More information about advance directives is available at www.idph.state.il.us.
14. **Right to Pain Management:** Your concerns about pain will be taken seriously. You will receive information on pain management options, and the staff is committed to responding quickly to reports of pain.

Patient's Responsibilities

1. **Respect for Others:** Be considerate of other patients and staff, and assist in minimizing noise, smoking, and other distractions.
2. **Respect for Property:** You are responsible for respecting the property of others and the facility.
3. **Financial Responsibility:** You are responsible for fulfilling your financial obligations to the surgery center.
4. **Adherence to Rules:** You should observe the rules and regulations of the surgery center as they apply to your care.
5. **Understanding Your Treatment:** You are responsible for understanding the planned course of treatment and communicating any confusion or concerns.
6. **Keeping Appointments:** You are responsible for keeping scheduled appointments and notifying the facility if you cannot attend.
7. **Providing Accurate Information:** You must provide complete and accurate information regarding your current health concerns, medical history, medications, and any changes in your condition.
8. **Following Instructions:** Follow the prescribed rules of the facility during your stay. If instructions are not followed, you may forfeit the right to care at the facility and be responsible for the consequences.
9. **Pain Management Communication:** Ask your doctor about pain expectations and management, discuss options, and help assess your pain. Inform your doctor if your pain is not relieved, and discuss any concerns about pain medications.

Acknowledgment

By signing below, you acknowledge that you have received this Notice of Privacy Practices and had the opportunity to ask questions related to its content.

Print Name: _____

Patient Signature: _____ **Date:** _____

Barrington
Ambulatory Surgery Center™

Member Appeal Authorization Form

Date: _____

Member Name: _____

Member ID #: _____

I, the undersigned, hereby authorize Barrington Ambulatory Surgery Center billing representative to appeal to the insurance company named below on my behalf:

Insurance Company Name: _____

I further request that all correspondence regarding this appeal be directed to said representative throughout the appeal process. I understand that such communications may include confidential information, including but not limited to medical and financial details contained in my insurance file related to services provided at Barrington Ambulatory Surgery Center, in connection with the appeal being made.

I acknowledge that this information is privileged and confidential and will only be released as specified in this authorization, or as required by law. This authorization will remain valid for a period of one year from the date signed.

Print Name: _____

Patient Signature: _____ **Date:** _____