Acknowledgment of Notice of Privacy Practices and Consent

The federal law "Health Insurance Portability and Accountability Act" (HIPAA) requires that notice of privacy practices and confidentiality of the institution is provided and that there is evidence of such notification. The Patient Rights and Responsibilities act requires that in order to provide our services we must get your authorization (consent in accordance with HIPAA) to use and disclose your protected health information for treatment, payment and other transactions or operations for healthcare purposes carried out by our organization.

To comply with the provisions of law, our institution has executed the "Notice of Privacy Practices" and asked you to sign this acknowledgment as evidence of notification of said notice and your authorization to use and disclose your health information for purposes of treatment, payment and other healthcare operations. It also authorizes the organization, its workforce (including employees, volunteers, etc.) and its business partners, to use and disclose your protected health information for treatment, payment, healthcare operations and transactions.

By signing, you acknowledge that you have been notified about our privacy practices and consent to the use and disclosure of your health information as described in this Notice. Review it carefully, sign and date where indicated.

Finally, remember that the organization has reserved the right to revise, change or amend the policy and practice regarding use and disclosure described in the Notice at any time. If you are interested in the latest version of the Notice, please contact the Privacy Officer at this telephone number (787)522-2825.

I, _____, certify that I have read the provisions of "Notice of Privacy Practices", I understand and agree with the terms and conditions expressed in said notice and I consent and authorize the use and disclosure of my health information for treatment, payment and other transactions and operations for my healthcare defined by law.

Patient Name	*Record Number*
Patient Signature	*Date*
Name of Authorized Representative(if applicable)	*Representative Signature(if applicable)*
Relation with Patient	*Date*

For Official Use Only

After reasonable efforts to obtain the Acknowledgement of Privacy Practices and Consent, it was not possible due to :

- *Patient refused to Sign the Notice*
- *Communication Barrier*
- *Other (specify)*

Employee Name	*Employee Signature*	*Date*

Certification of Medical Insurance

For the present I certify that I, _____

1. *Only possess the medical insurance(s) which the copy of the card(s) appears posterior to this document.*

2. *In case of omission or offering incorrect information that obligates the medical insurance to reject the payment of provided services, I authorize that these can be billed to me.*

3. *In the case that the surgeon practices a different procedure not authorized by the medical insurance, I will also be responsible of making the payment.*

4. *In the case that the surgeon does not meet the requirements of Medicare and you wish for your surgeon to continue with the programmed operation, you agree to pay the services as a private patient without the right of reimbursement.*

If there were any other reason for which the medical insurance(s) reject the payment, I make myself responsible of the total debt. I commit to pay as soon as possible any pending balance. A copy of this document is valid as the original.

_____

Patient Signature

_____

Admissions Officer Signature

_____

Date/Time

Rev 1/2011

Form for Disclosure of Medical Records

I, _____ authorize the disclosure of my medical record to _____.

This release authorizes _____, to receive a copy, examine and photocopy, and any other way reproduce my medical record.

The records that you are authorized to disclose include the following marked below:

- ☐ *Records of health insurance claims or health coverage*
- ☐ *Forms and resumes of claims*
- ☐ *Explanation of Benefits*
- ☐ *Coverage or Letters of Denial*
- ☐ *All of the parts of the medical record, including the hospitalization records and of the doctor's office*

Also, I authorize and request that you accept a copy of this authorization in substitution of the original.

_____

Patient Signature

_____

Date/ Time

Notification and Acceptance of the Patient

Notice of Privacy Practice

VISTA Ophthalmic Ambulatory Center (VOAC) has provided written notice, legibly and in the required language, ensuring understanding of the politics of privacy practices to patients and their companions.

Notice of Patient Rights

VISTA Ophthalmic Ambulatory Center has established a Patient Bill of Rights; it has been explained verbally and has been provided in writing, legible and in the required language, ensuring their understanding by the patient or his companion before the date of your procedure. **VOAC** expects that respecting these rights will contribute to a more effective patient care and greater satisfaction from patients, doctors and the facility.

Financial Disclosure

VOAC is a private corporation and registered with the Department of the Commonwealth of Puerto Rico, to provide ambulatory ophthalmic surgery services. **VOAC** has informed the patient prior to the date of their surgical procedure that their doctors may have proprietary/financial interest in this facility. You as a patient, have the right to choose the facility of your choice to perform your procedure.

Patient Advance Directives

We recognize and respect the necessity of the patient to participate actively on deciding his/her medical attention. Since the reach of care in this facility is limited to elective ambulatory surgical procedures, any situation that endangers life will be treated immediately with measures to maintain the patient with life. Simultaneously, the medical emergency system will be activated for emergency transport to a hospital. The acceptance of this policy does not revoke or invalidate any current guideline anticipated patient or power of attorney granted or lawfully signed by legal counselor for the treatment and patient health care.

Please check the appropriate box: Have you executed an advance directive regarding care and medical treatment for your health, a living will or power of attorney to authorize another person to make decisions for you about your health?

☐ Yes, I have advance directives, living will and/or granting of power to third person, by attorney legal document regarding my care and treatment decisions about my health.

☐ No, I have advance directives, living will and/or granting of power to another person, by attorney legal document regarding my care and treatment decisions about my health.

☐ I would like additional information about advance directives in health care.

I also certify that I received the **Patient Satisfaction Survey** and **Pain Management Education Material**

By signing below I certify that all information described above was provided prior to the date of my procedure and therefore I affirm that I have read and understood the information regarding the privacy practices, patient rights, financial certification and guidelines advance. I hereby accept **VOAC** policies. I also certify that if I requested additional information, it was granted.

_____ _____

Patient Signature or Representative *Date and Time*

_____ _____

Witness Signature *Date and Time*

Anesthesia Services

ASSIGNMENT OF BENEFITS AND INSTRUCTION FOR DIRECT PAY
to private anesthesiologists, groups and insurance companies.

I hereby authorize my insurance company to pay through check addressed to:

RCP Anesthesia, PSC
PO Box 366257
San Juan, Puerto Rico 00936-6257

The professional services and medical costs covered under my insurance policy shall be paid directly to the service provider. Otherwise, I commit to pay as soon as possible any balance pending or denied by the medical insurance for the professional services received.

A photocopy of this assignment will be considered effective and valid as the original.

I authorize the use of any information necessary and pertinent to the services to any insurance company, insurance agent or lawyers related to this case.

_____
Name of Policyholder

_____ _____
Patient Name *Patient Signature*

_____ _____
Witness *Date/ Time*