ASP SURGICAL, LLC 245 E. Main Street, Ramsey, NJ 07446 Website: www.dranthonypozzessere.com
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Dear Patient,

Welcome to our practice. According to the Health Insurance Portability and Accountability Act (HIPAA) and further expanded by the Health Information Technology for Economic Clinical Health Act (HITECH), federal regulations require that each patient is assured that his/her protected health information (PHI) is safeguarded. The elements of this notice and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI. This is necessary to support your relationship with the practice of **ASP Surgical, LLC**. This disclosure serves to highlight some of the major components of HIPAA.

I understand that as part of my health care, this office originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that disclosure of PHI from the office of ASP Surgical, LLC is permitted in compliance with HIPAA for the following reasons: treatment, payment, and health care operations.

Treatment. Treatment means the provision, coordination, or management of your health care and related services by ASP Surgical, LLC and health care providers involved in your care.

Payment. Payment means our activities to obtain reimbursement for the medical services provided to you, including billing, claims management, and collection activities. Payment may also include your insurance carrier's efforts in determining eligibility, claims processing, assessing medical necessity, and utilization review. Payment may also include activities carried out on our behalf by one or more of our collection agencies or agents in order to secure payment on delinquent bills.

Health Care Operations. Health care operations mean the legitimate business activities of our practice. These activities may include quality assessment and improvement activities; fraud and abuse compliance; business planning and development; and business management and general administrative activities. When we involve third parties in our business activities, we will have them sign a Business Associate Agreement obligating them to safeguard your PHI according to the same legal standards we follow.

Authorization Is Specifically Required for Use and Disclosure Of:
- Psychotherapy notes, HIV/AIDS, substance abuse and genetic information and PHI not otherwise allowed by the Privacy Rule.
-For most marketing communications, the sale of PHI and for research use unless a regulatory permission or exemption applies.

You Have the Right:
- To request a copy of your paper/electronic medical record.
-To know if a breach occurs which compromises the privacy or security of your information.
-To opt out of fundraising.
-To restrict disclosures of PHI to health plans if you have paid for services out of pocket and paid in full.

Complaints:
If you feel your privacy rights have been violated, you may complain to us or to the U.S. Department of Health and Human Services.

Please review our privacy policy for a full disclosure of your rights, your choices and our responsibilities. It is conveniently displayed in our waiting room or a coy is available upon request.

HIPAA Privacy Information

YOUR NAME: _____ DOB: _____

It is customary for ASP Surgical, LLC, to communicate with you regarding appointment, medical, and payment information via telephone, cell, mail, or our secure Patient Portal. By default, we utilize the telephone numbers and address that you provide us on our "Patient Information" form and/or those that were communicated verbally when making your appointment. We may also use what was provided to the health care facility where you received the services of ASP Surgical, LLC. In addition, we may transfer your PHI to other treating health care providers and to your insurance carrier electronically or by fax. You have the right to request we communicate with you by alternative means. Please make your request in writing to ASP Surgical, LLC, 245 East Main Street, Ramsey, NJ 07446 ATTN: Privacy Officer

Who may we contact in case of an emergency?

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ Tele #: _____ DOB: _____

********** MAY WE DISCUSS YOUR MEDICAL INFORMATION **********
(MEDICAL HISTORY, TEST OR LAB RESULTS)
WITH THE EMERGENCY CONTACT YOU NAMED ABOVE?
YES _____ NO _____

Is there someone else OTHER THAN those permitted under the guidelines of HIPPA for treatment, payment, and health care operations **with whom we may discuss your medical information?**

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ Tele #: _____ DOB: _____

I acknowledge and understand the notice of privacy practices from this office detailing the uses of my medical information, communication practices, and my rights concerning my information kept on record at this office. I understand that a detailed notice is available for my immediate review or a copy for my records.

Signature of Patient or Legal Representative: _____ Date: _____

If signed by Patient Representative, give relationship: _____

Signature of Witness: (Office) _____