Welcome To *Advanas Foot & Ankle Specialists®*

We want to thank you for trusting ***Advanas Foot & Ankle Specialists®*** with your healthcare needs.

At ***Advanas Foot & Ankle Specialists®*** we pride ourselves on being a pleasant environment with caring staff whose goal is to provide the latest in treatment options for every foot and ankle problem.

We understand you have many options when it comes to your foot and ankle care and we are honored that you have chosen us.

Again, let us thank you for your confidence in us.

Sincerely,

Dr. Trevor Neal
Dr. Christopher Bussema
Dr. Kathleen Bickle
Dr. Robert Monfore

Patient Demographics

Advanas Foot & Ankle Specialists/Sturgis Surgi-Care

Patient Information:

Name: (First)_____(Middle Initial)_____(Last)_____

Address:_____**City, State:**_____**Zip Code:**_____

Date of Birth:_____ **Sex:** ( )Female ( )Male **Marital Status:** ( )Single ( )Married ( )Divorced ( )Widowed

Home Phone #:_____ **Cell Phone #:**_____

Social Security #: _____

Email Address:_____

Race: ( )White ( )Black/African American ( )Latino/Hispanic ( )Other

Ethnicity: ( )Hispanic/Latino ( )Other **Preferred Language:** ( )English ( )Spanish ( )Other

Employer:_____ **Occupation:**_____

Employer Address: _____ **City, State:** _____**Zip Code:**_____

Employer Phone #: _____

Guarantor/Responsible Party:

Full Name:_____ **Date of Birth:**_____ **S.S. #:**_____

Relationship to Patient: ( )Self ( )Spouse ( )Parent ( )Guardian ( )Other

Employer:_____ **Occupation:** _____

Employer Address:_____**City, State:**_____**Zip Code:**_____

Employer Phone #: _____

Who is your Primary Care Physician?

Name: _____

Physicians Address/Location: _____

Date of last visit?_____ **Phone #:** _____

Preferred Pharmacy:_____ **Location:**_____

Foot Health Information:

What is your current foot/ankle condition? _____

When did it begin? _____

Have you seen another doctor for this condition? _____ **Whom?**_____

How have you treated this condition so far?_____

How did you hear about us? We would like to thank them!

Name: _____**Phone #:** _____

Address: _____**City, State:**_____**Zip Code:**_____

Signature of Patient or Guardian: _____***Date:*** _____

***OFFICE USE ONLY*: Entered By:**_____**Date**_____

Public: Master File - Overall: Clerical - Welcome To Our Office

Notifications	Please Initial In Box
I hereby give the physicians at Advanas Foot & Ankle Specialists/Sturgis SurgiCare permission to examine and treat my feet. I also authorize the release of medical or other information necessary to process any insurance claim, and authorize payment of medical benefits to Advanas Foot & Ankle Specialists/Sturgis SurgiCare. I certify that the information given to the staff at Advanas Foot & Ankle Specialists is true and correct to the best of my knowledge and will notify Advanas Foot & Ankle Specialists/Sturgis SurgiCare. If any of this information changes.	
PATIENT RIGHTS AND RESPONSIBILITIES: • I have been informed of my patient rights and responsibilities and will follow them completely.	
ADVANCE DIRECTIVES: • I have been informed of my rights to formulate an Advance Directive and understand that I am not required to have an Advance Directive in order to receive medical treatment in this health care facility. • I understand the policy of this facility and Sturgis SurgiCare is to attempt to resuscitate all patients requiring such service. I further understand should this be the case I will be transferred to a local hospital. • I **HAVE** formulated an Advance Directive. Initialing this shows you, we do not honor them, we will do everything in our power to save you as long as you are in the office or surgical suite.	
FINANCIAL POLICY: I have read, understood and agree with all three pages of the financial policy. I also understand that I may receive a copy upon my request.	
Consent to release: I authorize my physician at Advanas Foot & Ankle Specialists to obtain any outside information regarding my health or prescription history from external sources.	
DISCLOSURE OF OWNERSHIP: Advanas Foot & Ankle Specialists and Sturgis SurgiCare was formerly owned by Dr. Trevor Neal, In 2018, Doctors Kathleen Bickle, Christopher Bussema, Robert Monfore, along with Dr. Trevor Neal formed a cooperation of joint ownership. The owner's mission is to provide the upmost service in the area of Podiatry. Please be advised of the following: • The facility may have a financial relationship with your physician as indicated above. • A schedule of typical fees for services provided by the facility may be available at your request. • You may have the right to choose where to receive services including an entity in which your physician may have a financial relationship.	

YOUR CONFIDENTIAL COMMUNICATIONS

Persons whom we can contact regarding your treatment, care, appointments, or financial arrangements.

Emergency Contact:_____Phone#:_____
Phone # we can leave a detailed message on:_____
Spouse (Name):_____
Children (Name):_____
Care Giver (Name):_____
Power of Attorney (Name):_____
Lawyer (Name):_____
Institutions (Name):_____
Other(Name(s)):_____

If no one is listed in this section we will only be able to speak to you regarding your personal health information.

I HAVE RECEIVED A COPY OF ADVANAS FOOT & ANKLE SPECIALISTS/STURGIS SURGICARE/TREVOR NEAL D.P.M. NOTICE OF PRIVACY PRACTICES.

Signature:_____ Date:_____

Public: Master File – Overall: Clerical – Notification Entered By:_____ Date:_____

PATIENT RIGHTS AND RESPONSIBLITIES

In recognition of our responsibility in rendering patient care, these rights and responsibilities are affirmed in the policies and procedures of

Advanas/ Sturgis SurgiCare

The patient has the right to

- ***To*** be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need of privacy
- ***To*** an environment that is safe and secure for self and property.
- ***To*** confidentiality of information gathered during treatment
- ***To*** prompt and reasonable response to questions and requests.
- ***To*** know who is providing and is responsible for his or her care.
- ***To*** know what patient support service are available, including whether an interpreter is available if he or she does not speak English
- ***To*** know what rules and regulations apply to his or her conduct.
- ***To*** be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- ***To*** be given, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Advance Directives.
- ***To*** receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- ***To*** receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- ***To*** receive impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- ***To*** receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- ***To*** know if medical treatment is for purposes of experimental/research and to give his or her consent or refusal to participate in such experimental research.
- ***To*** express grievances regarding any violations of his or her rights, through the grievance procedure of health care provider which served him or her.
- ***To*** participate in all aspects of health care decisions, unless contraindicated by concerns for their health.
- ***To*** appropriate assessment and management of pain

The patient is responsible

- ***For*** providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- ***For*** reporting unexpected changes in his or her condition to the health care provider.
- ***For*** reporting to the healthcare provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- ***For*** following the treatment plan recommended by the health care provider.
- ***For*** keeping appointments and when he or she is unable to do so for any reason, for notifying the Facility
- ***For*** his or her actions if he or she refuses treatment or does not follow the health care providers instructions.
- ***For*** assuring that the financial obligations of his or her health care fulfilled as promptly as possible.
- ***For*** following Facility rules and regulations affecting patient care and conduct.
- ***For*** consideration and respect of the Facility staff and property.
- ***For*** asking what to expect regarding pain and pain management.

If you have any concerns or complaints regarding your care, treatment, or services, please contact Paula Hollister, Director of Operations at (269)651-2320.

Financial Policy

Thank you for choosing us as your foot and ankle specialists. We share your concern regarding the rising cost of healthcare. Because of this, we have established financial policies which are necessary to help hold down the overall cost of your care. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. All Co-pays and deductibles are due at the time of service unless prior arrangements have been made. We accept cash, check, money order, Visa, MasterCard, American Express, Discover, Paypal and Care Credit.

Due to regulations and changes in the healthcare industry, we are required to secure payment. This can be achieved by providing us with current proof of coverage, postdating a check, cash or placing a credit card on file with us. Our Corporate Collections Officer will help determine how is best to proceed with your balance. You may be asked to sign a promissory note should your balance be over $100.00. Our Corporate Collections Officer will also help you determine if your case would qualify for financial hardship should you run into difficulties. If this is the case, please contact our Corporate Collections Officer immediately. The sooner arrangements are made the less likely additional charges will occur.

Self Pay:
A minimum deposit of $200.00 or the actual charge, whichever is less, is due at the time of service. Any subsequent visit charges will be due at time of service. If you cannot pay in full, you will need to set up and adhere to a payment plan with our Corporate Collections Officer.

Workers Compensation:
If you are here as a result of a work related injury, we are required to have a letter or statement authorizing your treatment from your employer or Workers Compensation carrier. The letter should include the claim number, address, adjuster's name and phone number. Your employer's human resource office should be able to assist you with obtaining this information. Without this information, you will only be seen on a self-pay basis until arrangements and the necessary paperwork has been completed.

Insurance:
Due to the extremely large number of insurance companies, it is impossible for us to be acquainted with each individual policy's guidelines. While we will be of any assistance possible, your policy is your responsibility to be familiar with. We will gladly set an appointment to talk with you and your insurance agency together to help ensure and secure payment from your insurance company.

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____

The following are common terms associated with insurance:

- EOB – Explanation of Benefits: This is a statement from your insurance company of what they have allowed, paid or denied.
- Deductible: The amount you are responsible for each year prior to any payment being made from your insurance company
- Co-Pay: A set fee you are legally responsible for at each office visit or procedure.
- Co-Insurance: A percentage of the services rendered not paid by your insurance company
- R&C – Reasonable and Customary: The amount your insurance company determined they will pay for any specific procedure.

Your insurance policy is a contract between you and your insurance company. In order to help you with your insurance, we require a copy of your insurance card. Therefore, please have your insurance card every time you visit the office. If current information is unable to be obtained at the time of service, it will be your responsibility to pay your balance in full at that time of service.

As a courtesy, we will file your insurance claim for you. You must assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor(s), Advanas Foot and Ankle Specialists, Sturgis SurgiCare, Trevor Neal, D.P.M., Christopher Bussema, D.P.M., Kathleen Bickle, D.P.M., and Robert Monfore, D.P.M. or Harshini Avula D.P.M. directly. Due to the ever changing insurance policies and their names, we will attempt to submit claims on all policies with the exception of Medicaid, as it is not a policy we are in network with at this time. Any patient who chooses us for their care, and is insured through Medicaid, will be required to pay self-pay rates and submit their own claims. We will provide any information we have available to assist you.

Your insurance is your responsibility and as such it is your responsibility to contact your insurance to make sure we are in network with them. Any assistance we can provide please let us know. It is most common for the insurance companies to make the following statement at the beginning of any call. This call may be monitored and recorded for security purposes. Please remember any statements made regarding coverage is not a guarantee of payment. While we are used to this statement and most times the insurance still pays, we feel you should be made aware of how they state things so we cannot ever be 100% sure they will make the payments.

Normally, you will only receive a bill from us once your insurance company has paid. We send your insurance claim within 30 days of services and most generally within 7 days of service. However, if your insurance company does not pay, or we have not heard from them within 90 days, you will receive a statement from us as we will assume your insurance company has made payment to you directly. Please remember that it is your responsibility to promptly answer any requests for information from your insurance company which might hold up processing of your claim. Most insurance companies will send you an EOB within 45 days. If you have not heard from them we encourage you to contact them to determine the status of your claim.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or you do not have an authorization, you will be

responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges of any services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

If you have two medical insurance plans, it is your responsibility to inform us which plan is your primary (first), and which is your secondary (second). You must inform us if one or both insurance plans change or are no longer in effect. We will gladly bill the secondary insurance for you as long as the balance remaining after the primary insurance has paid is greater than $100.00. If the balance remaining after the primary insurance has paid is below $100.00 you will be responsible for the payment and the filing of the claim with your secondary insurance if you wish. Also please note that all billing is done through our billing office located in Sturgis, Michigan. You may receive notice from us or your insurance company with Advanas Foot and Ankle Specialist information.

Medicare:

We accept Medicare assignment. You are responsible for your deductible, and co-insurance, any service deemed Medically Unnecessary or non-covered services or supplies, and the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance, we will submit the claim for you. However, not all supplemental insurances cover all services so any remaining balance will be billed to you.

Fees and Payments:

In order to control costs, payment for all co-pays and deductibles is expected at the time services are performed. If you are unable to do so, please discuss your situation with our Corporate Collections Officer so special arrangements can be made. If arrangements have not been made and you are unable to pay your co-pay, a $25.00 billing fee will apply. We will make every effort to accommodate unusual circumstances that make your financial obligations difficult to fulfill. If you are suddenly going through financial hardship, please contact our Corporate Collections Officer to discuss your situation.

The fees for evaluation and treatment vary depending upon the complexity of your condition and the treatment required.

There are fees for requesting medical records. The fee depends on your file size and the complexity of your care. Fees can range from 25.00-250.00 so please determine the amount you wish to spend prior to obtaining the records.

There is a restocking fee for products that are eligible to be returned. This fee will be the minimum of 65.00 for products or durable medical equipment returned to our facility in great condition.

Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due on your account at this office.

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____

There are certain procedures that require prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the procedure.

As a courtesy to our patients, you are have the option to place your credit card on file with us. Any balance remaining after your insurance has paid will be placed on your credit card. Please ask the receptionist for a copy of our payment agreement if you would like this option.

There is a $50.00 service fee for all returned checks. You insurance company will not cover this fee. In the event of a returned check you may also be placed on a "Cash Only" basis.

If you have any questions regarding your treatment, your account or our office policies, please phone during business hours. Our main concern is taking care of you and your loved ones. Please do not hesitate to talk with our Corporate Collections Officer or Director of Operations should you find yourself in a situation you feel needs discussed.

Thank you for your continued support.

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____

Notice Of Privacy Practices

Effective Date: *1-1-2014*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Paula Hollister at 269.651.2320.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our Medical Records Office. We have up to 30 days to make your Protected Health Information available to you

and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Paula Hollister, Facility Director.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Medical Records.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Paula Hollister, Facility Director. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Paula Hollister, Facility Director. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, simply ask at the front desk or contact Paula Hollister, Facility director, or mail a request to 102 S. Lakeview Ave. Sturgis MI, 49091.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Paula Hollister, Facility Director, by mail at 102 S. Lakeview Ave. Sturgis, MI 49091. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.

102 S. Lakeview Ave. Sturgis, MI 49091

Dr. Trevor Neal, Dr. Christopher Bussema,
Dr. Kathleen Bickle & Dr. Robert Monfore

Consent to Treat

*(For **NON-PARENT** caregivers of minor children when a parent is not present.)*

_____ _____

(Childs Name) ***(Date of Birth)***

I/we authorize _____ who is _____

(Name of adult who is the NON-Parent) ***(grandparent, aunt/uncle, etc.)***

to the child and a caregiver to this child to consent to any examination, x-ray, medical or surgical diagnosis, injections, or treatment to be provided to said child when such services are recommended and supervised by Physicians and Staff at Advanas Foot and Ankle Specialists. I/we authorize Advanas Foot and Ankle Specialists to call in, at their discretion, any necessary consultants.

I understand that, despite this consent, Advanas Foot and Ankle Specialists, in its sole discretion, **may decide not to act on this consent**, and instead require my presence during my child's treatment and care.

I also understand that **I am financially responsible** for any co-pays and charges not covered by my insurance which are incurred as a result of this consent for treatment and care.

Unless it is revoked sooner in writing, this consent remains in effect until my child is…

[ ] 18 Years Old **[ ]** until the _____ of_____, 20____

Parent/Legal Guardian Phone #: _____

_____ _____

(Parent/Legal Guardian Signature) ***(Date)***

_____ _____

(Witness Signature) ***(Date)***