NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

This Notice of Privacy Practices tells me my rights, and Bay Surgical Specialists, PA duties regarding my protected health information. This Notice of Privacy Practices describes how my protected health information is to be used by Bay Surgical Specialists, PA to diagnose and treat me, to obtain payment of services rendered, and to communicate with me and with pertinent outside facilities while I am a patient of Bay Surgical Specialists, PA.

My protected health information is any information collected by Bay Surgical Specialists, PA about me. Bay Surgical Specialists, PA has the right to use and disclose my protected health information to diagnose and treat me. Bay Surgical Specialists, PA has the right to use and disclose my protected health information to collect payment for services rendered.

This Notice of Privacy Practices is posted on bulletin boards around the waiting room. If my registration papers were mailed to me a copy was included. I may request a copy of The Notice of Privacy Practices of Bay Surgical Specialists, PA at any time. If the current Notice of Privacy Practices is revised, I am entitled to review and obtain a new copy at any time. I have the right to review Bay Surgical Specialists, PA's Notice of Privacy Practices before I sign this form.

I acknowledge that I have been given the opportunity to read The Notice of Privacy Practices of Bay Surgical Specialists, PA and have been given the opportunity to obtain a copy.

_____ _____

Signature of Patient or Personal Representative Date

CONSENT AND ASSIGNMENT OF BENEFITS

Bay Surgical Specialists, PA is contracted to various health insurance programs, including Medicare, and accepts assignments only for those health insurances. If a contract exists between my insurance company and Bay Surgical Specialists, PA, Bay Surgical Specialists, PA will file my health insurance. I request that payment be made by my insurance on my behalf to Bay Surgical Specialists, PA. I agree to pay any portion of my charges rendered by Bay Surgical Specialists, PA that my contracted health insurance determines is my responsibility. In the event a charge is determined to be cosmetic, I agree to pay for the cosmetic services in full at the time service is rendered.

If I do not have a health insurance plan that Bay Surgical Specialists, PA is contracted with, I agree to pay all fees in full at the time services are rendered.

I understand that I am ultimately responsible for payment of my medical bill. If it becomes necessary for Bay Surgical Specialists, PA to collect payment, I understand that I will be responsible for legal costs, including attorney's fees.

I understand that as a result of refusal to sign this form, or if I have altered this form in any way, Bay Surgical Specialists, PA may refuse to diagnose and treat me. I have the right to revoke this consent and assignment of benefits in writing except for services that have already occurred.

_____ _____

Printed Patient Name or Personal Representative Date

_____ _____

Signature of Patient or Personal Representative Date

MEDICARE PATIENTS MUST ALSO READ AND SIGN BELOW

I request that payment of authorized Medicare services rendered by Bay Surgical Specialists, PA be paid to Bay Surgical Specialists, PA I agree to pay any portion of my charges rendered by Bay Surgical Specialists, PA that Medicare determines to be my responsibility. In the event a charge is determined to be cosmetic, I agree to pay for the cosmetic services in full at the time services are rendered.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date