PARK MEADOWS COSMETIC SURGERY

7430 East Park Meadows Drive, Suite 300 · Lone Tree, CO 80124
T: 303.706.1100 · TF: 800.844.2496 · F: 303.790.7322

FINANCIAL POLICY

The following is a financial agreement for services rendered by Park Meadows Cosmetic Surgery, PC and Park Meadows Outpatient, LLC, Dr. Jeremy Z. Williams, or Dr. Christopher G. Williams. We strongly believe that our financial policies incorporate judicious business practices, allowing us to provide our patients with the highest quality of care, while maintaining cost-effective fees. We accept most insurance; we are in-network with some, and out-of-network with others. Please take a few moments to thoroughly read and sign this agreement regarding your obligations for services rendered.

POLICY—COSMETIC (SELF-PAY) / AESTHETICS TREATMENTS

·A deposit is required to schedule surgical procedures as further described in your proposed Treatment Plan.
·Surgical fees, facility fees and anesthesia fees are due in full at your pre-surgical visit, typically scheduled two weeks prior to surgery.
·Any adjunct procedures, deemed medically necessary at the time of surgery, as discussed, will be an additional expense.
·All treatments/injections must be paid in full at the time of service. This includes all forms of payment from 3rd parties (ie Alle).

POLICY—INSURANCE

·Full payment of your estimated out-of-pocket expense is due at your pre-surgical visit, which is typically two weeks prior to surgery. Because this is an estimate there may be additional expense due, or a refund due, once your insurance company issues its' Explanation of Benefits. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.
·You will receive multiple Explanation of Benefits from the insurance company as well as multiple invoices from other providers during your surgery. The multiple providers include: surgeons, anesthesiologists, surgery center or hospital, pathology, etc.
·Any adjunct procedures, deemed medically necessary at the time of surgery, will be an additional expense.
·It is a patients' responsibility, prior to surgery, to verify insurance coverage and benefits. Even though it is your responsibility, as a courtesy we verify with your insurance company if a pre-determination, a pre-authorization or a pre-certification is necessary prior to any surgical procedure. As a courtesy, we will bill your insurance company for the date of service. Failure to provide all necessary billing information will result in full patient financial responsibility. This includes failure to provide information related to secondary insurance and coordination of benefits.
·If the insurance company pays patient directly, the patient must forward the check to us within 2 weeks.
·Any service determined as a non-covered benefit or excluded service by the insurance company is the patient's responsibility.

IN-NETWORK: Our office will conduct the pre-authorization with your insurance provider. As a courtesy, we will verify your eligibility, benefits and out of pocket payment requirements with your insurance provider (primary and secondary insurances). We will also notify you of any upfront payment requirements. It is our contractual obligation to collect all copays, deductibles, and coinsurance from the patient prior to surgery. We will promptly refund any overpayments made on your part and we will collect on any underpayments determined by your insurance policy.

OUT-OF-NETWORK: Our office will conduct the pre-authorization with your insurance provider. As a courtesy, we will verify your eligibility, benefits and out of pocket payment requirements with your insurance provider (primary and secondary insurances). We will also notify you of any upfront payment requirements. Claims will be submitted, and the patient is responsible for the amount equivalent to the in-network contracted amount but will not exceed the out-of-pocket maximum.

THIRD-PARTY PROVIDERS

·I understand that third-party providers may be involved (as an example, anesthesiologists) if I have a surgical procedure. I authorize third-party providers to release to my insurance company any and all information necessary for the processing of claims.

AVAILABLE FINANCING OPTIONS

·We accept cashier's checks, money orders, Visa, Master Card, Discover, and American Express.
·Financing is available to qualified applicants. Rates are set by each individual financing company and are subject to change.

LATE APPOINTMENT / NO SHOW / CANCELLATION POLICY

·I understand that if I am late for an appointment, the appointment may be rescheduled.
·Cancellations will be accepted up to 24 hours in advance of the scheduled appointment. Any no-show or cancelled appointment within 24 hours may be subject to a $50.00 cancellation fee.

IF YOU HAVE ANY QUESTIONS REGARDING THIS FINANCIAL POLICY, PLEASE ASK FOR CLARIFICATION PRIOR TO SIGNING BELOW.

I have read and understand the Park Meadows Cosmetic Surgery, PC and Park Meadows Outpatient Surgery, LLC Financial Policy and agree to abide by its terms.

_____ _____

Signature of Patient or Guardian Date

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PATIENT RIGHTS

OUR MISSION

The mission of Park Meadows Cosmetic Surgery, PC and Park Meadows Outpatient Surgery, LLC is to provide the best possible care to our patients with compassion, skill, knowledge, information and continued observation. Our desire is to treat each patient like we would want to be treated, with kindness and truth.

Quality of Care

You have the right to:

· Access to care regardless of sex, disability, national origin, age, color, race, religion or source of payment.
· Respectful care free from abuse, neglect or harassment, which recognizes and maintains your dignity, values, medical or surgical needs.
· Care in a safe environment with adequate staffing.
· Identification of all healthcare providers and their professional credentials.
· Care from a healthcare provider in which their professional credentials have been verified.
· Knowledge of who is primarily responsible for your care.
· Interpreters and/or special equipment to assist with any language needs.

Decision Making

You or your representative has the right to:

· Be informed of your rights before patient care is given or discontinued whenever possible.
· Receive complete and current information regarding your health status in terms you can understand.
· Participate in care planning, treatment and discharge recommendations including required/recommended continuation of healthcare following discharge.
· Receive an explanation of any proposed procedure or treatment, including risks, side effects and treatment alternatives.
· Make informed decisions regarding care and treatment.
· Participate in managing your pain effectively
· Request a specific treatment.
· Refuse or discontinue a treatment to the extent permitted by law and to be informed of the consequences of such refusal.
· Request a second opinion or to choose or change your healthcare provider.
· Have persons of your choice and your physicians promptly notified of admission.
· Review the Advanced Directives policy.
· Assign a Medical Power of Attorney.
· Formulate a Living Will.
· Accept, refuse or withdraw from clinical research.
· Receive care and/or a referral according to the urgency of your situation. When medically stable, you may be transferred to another facility if recommended by your physician.

Access to Medical Records

You or your representative has the right to:

· Request a copy of your medical records in writing via a records release form.
· Be provided a copy of your medical records within 30 days of receiving your request.

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Billing

You or your representative has the right to:

· Receive, review, and obtain a written copy of estimated charge(s) of services prior to undergoing treatment.
· A complete explanation of your bill.

Grievance Process

You and your representative has the right to:

· Voice a complaint of mistreatment, neglect, verbal, mental, sexual, or physical abuse to your healthcare providers and administrators without a fear of reprisal.
· Voice a complaint of treatment care or failure of to your healthcare providers and administrators without fear of reprisal.

File a grievance or complaint with the Administrator.
Contact: Park Meadows Cosmetic Surgery, PC
Park Meadows Outpatient Surgery, LLC
7430 East Park Meadows Drive, Suite #300
Lone Tree, CO 80124
(303) 706-1100

File a grievance or complaint with the appropriate state agencies.
Contact: DORA -Department of Regulatory Agencies
1560 Broadway, Suite #1350
Denver, CO 80202
(303)-894-7690 http://www.dora.state.co.us

Contact: CDPHE
4300 Cherry Creek Drive South
Denver, CO 80246
(303) 692-2800 or 1-800-886-7689 http://www.cdphe.state.co.us

Contact: The Medicare Hotline
1(800) 633-4227
http://www.medicare.gov or
https://www.cms.gov/center/special-topic/ombudsman/medicare-beneficiary-ombudsman-home

File a grievance or complaint with The Joint Commission
Contact: Office of Quality Monitoring
The Joint Commission
1 Renaissance Boulevard
Oakbrook Terrace, IL 60181
(630) 792-5636 (800) 994-6610
complaint@jointcommission.org http://www.jointcommission.org

· We will review a grievance or complaint within 14 days. A written response will be provided within 21 days.
· If such mistreatment is confirmed, the grievance will be reported to local or state authority.
· You will receive written notice of the decision(s).

Ownership

Your surgeons each have an ownership of Park Meadows Outpatient Surgery, LLC as follows:

Surgeons: Jeremy Z. Williams, MD – 50%
Christopher G. Williams, MD – 50%

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PATIENT RESPONSIBILITIES

PROVIDING INFORMATION

You have the responsibility to:

· Provide accurate and complete information about your present complaints, past illnesses, hospitalizations, medications and other health-related matters.
· Report perceived risks in your care and unexpected changes in your condition.
· Understand your treatment plan and ask questions when needed.
· Understand your pre- and post- operative instructions, asking questions if you do not understand.
· Provide accurate and updated information for insurance and billing.

INVOLVEMENT

You have the responsibility to:

· Actively participate in your treatment by following your recommended treatment plan.
· To call us at any time if you have questions or concerns about your care or progress.
· Return for any follow up visits as requested.
· To take full responsibility for your actions, should you choose to refuse treatment.

RESPECT AND CONSIDERATION

You have the responsibility to:

· Act in a respectful and considerate manner towards healthcare providers, other patients, and visitors.

INSURANCE BILLING

You have the responsibility to:

· Know the extent of your insurance coverage; benefits, deductibles and pre-authorization requirements.
· To assume and fulfill financial responsibility for health care which is provided to you, your dependent, or designated minor. We will assist you filing appropriate claims with your insurance provider, as a courtesy; however, final responsibility for all uncovered charges rests with you.
· Call the billing office with questions or concerns (303) 706-1100.

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PRACTICE PRIVACY POLICY

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT, MINOR, MINOR'S PARENTS OR REPRESENTATIVES, OR EMANCIPATED MINORS OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your Personal Health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

· How we may use and disclose your PHI
· Your privacy rights in your PHI
· Our obligations concerning the use and disclosure of your PHI
· The terms of this notice apply to all records containing your PHI that are created or retained by our practice.
· We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current notice at any time. Unless otherwise required by law, your health record is the physical property of the health care practitioner or facility that compiled it. The information contained in the record belongs to you.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

HIPPA Privacy Officer at Park Meadows Cosmetic Surgery, PC
7430 East Park Meadows Drive, Suite 300 Lone Tree, CO, 80124
Or contact at (303) 706-1100

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUAL (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI:
TREATMENT: PMCS, PMOS, and third-party providers may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including, but not limited to, our doctors and nurses—may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment. We are prohibited to require individuals to waive any right as a condition for obtaining treatment, payment, or eligibility for enrollment or benefits.

PAYMENT: Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. The information on or accompanying the bill may include information that identifies

you, as well as your diagnosis, procedures and supplies used. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

HEALTH CARE OPERATIONS: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

TREATMENT OPTIONS: Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

APPOINTMENT REMINDERS: We may use and disclose your medical information to contact you that it is time to set up an appointment or remind you of an appointment you have scheduled.

HEALTH-RELATED BENEFITS AND SERVICES: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

INDIVIDUALS INVOLVED IN YOUR CARE OR RESPONSIBLE FOR PAYMENT FOR YOUR CARE: We may use or disclose your medical information to a family member, personal representative, or other personal involved in your health care or responsible for payment of your health care services. We may also tell your family or friends about your condition and that you are in the hospital. If you do not want us to share information with your family or friends, tell the hospital staff at the time you are admitted.

INCIDENTAL USE AND DISCLOSURE: Your medical information may be disclosed in situations that are incidental to an otherwise permitted use or disclosure. For example, sign-in sheets in physician offices or hospital registration areas may be used; physicians may confer with patients in semi-private rooms; physicians may confer with other health care professionals at the nurses' stations.

DISCLOSURES REQUIRED BY LAW: Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

FUNDRAISING: We may use and disclose your PHI for fundraising unless you opt-out.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

PUBLIC HEALTH RISKS: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
· Maintaining vital records, such as births and deaths
· Reporting child abuse or neglect
· Preventing or controlling disease, injury or disability
· Notifying a person regarding potential exposure to a communicable disease
· Notifying a person regarding a potential risk for spreading or contracting a disease or condition
· Reporting reactions to drugs or problems with products or devices
· Notifying individuals if a product or device they may be using has been recalled
· Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
· Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

HEALTH OVERSIGHT ACTIVITIES: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licenser and disciplinary actions; civil,

administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

LAWSUITS AND SIMILAR PROCEEDINGS: Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a law suit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

LAW ENFORCEMENT: We may release PHI if asked to do so by a law enforcement official:
· Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
· Concerning a death we believe has resulted from criminal conduct
· Regarding criminal conduct at our offices
· In response to a warrant, summons, court order, subpoena or similar legal process
· To identify/locate a suspect, material witness, fugitive or missing person

SERIOUS THREATS TO HEALTH OR SAFETY: Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

MILITARY: Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

NATIONAL SECURITY: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

INMATES: Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

WORKERS' COMPENSATIONS: Our practice may release your PHI for workers' compensation and similar programs.

You have the following rights regarding the PHI that we maintain about you:
CONFIDENTIAL COMMUNICATIONS: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you via phone, email, or fax. Patient is required to indicate preference of communication, including leaving accurate information, on Patient Information Form. In order to request a type of confidential communication, you must make a written request to the HIPAA Compliance Officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

REQUESTING RESTRICTIONS: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request unless services have been paid out-of-pocket in full. If we do agree to your request, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the HIPAA Compliance Officer. Your request must describe in a clear and concise fashion:
· The information you wish restricted
· Whether you are requesting to limit our practice's use, disclosure or both; to whom you want the limits to apply.

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INSPECTING COPIES: You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the HIPAA Compliance Officer in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

AMENDMENT: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the HIPAA Compliance Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

ACCOUNTING OF DISCLOSURES: All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the HIPAA Compliance Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

RIGHT TO A PAPER COPY OF THIS NOTICE: You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the HIPAA Compliance Officer.

RIGHT TO FILE A COMPLAINT: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the HIPAA Compliance Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the HIPAA Compliance Officer.

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ACKNOWLEDGEMENT OF

· Patient Rights
· Patient Responsibilities
· Practice Financial Policy
· Practice Privacy Policy

Patient Name _____

I hereby acknowledge that I have received the Patient Rights, Patient Responsibilities, Practice Financial Policy and Practice Privacy Policy established for Park Meadows Cosmetic Surgery, PC and Park Meadows Outpatient Surgery, LLC.

_____ _____

Signature of patient or patient representative Date