Fall General Surgery, LLC
Summary Notice

By signing below, I acknowledge that I have received information from Fall General Surgery, LLC on how to obtain a written notice of Fall General Surgery, LLC's privacy practices for protected health information. I understand the written notice will contain a description of how medical information about me may be used and disclosed and how I may access this information. I have received information explaining how to contact Fall General Surgery, LLC for further information and the date this notice was first effective. I understand that the written notice also contains:

- A description of the types of uses and disclosures that Fall General Surgery, LLC is permitted to make for treatment, payment or health care operations with or without my written authorization
- A description of each of the other purposes for which Fall General Surgery, LLC is permitted or required to use or disclose protected health information without my written authorization
- A description of uses or disclosures that may be limited or prohibited by law
- The description contains sufficient detail to make me aware of the uses or disclosures that are permitted or required by the federal privacy rule and other applicable law
- A statement describing my individual rights with respect to my health information and a description of how I may exercise this right
- A statement describing the Fall General Surgery, LLC duties under the federal privacy law
- A statement describing how I may express concern to the Fall General Surgery, LLC and the Secretary of the Department of Health and Human Services if I believe my privacy rights have been violated

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Please note that for us to release copies of your medical records to family members you must sign a release form; *this includes spouses*. Just ask the receptionist for the form.

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On the line below:

***Please LIST the Name*(s) of any person; for example: your care-giver, spouse, brothers, sisters, moms, dads, sons, daughters, etc., you would like to have *Access* to your *MEDICAL/BILLING INFORMATION*; for example: verifying appointments, picking up prescriptions, speaking to our billing department about your bill, speaking with the doctor about your care, etc., *on a regular basis*. *If you Prefer Not to list anyone below, please state No One or None*.**

List or No One _____

By signing below, I give permission for the above named people to have access to my medical and/or billing information on a regular basis and it allows Fall General Surgery LLC and its staff members to relate information regarding my care to these named people. I understand that this is effective for one (1) year from the date of my signature and does not grant access to my medical record.

Sign Here _____ _____

Signature of patient (or parent/guardian if patient is a minor) **Date**

Patient Name if the Patient is a Minor or a Patient Representative signed:_____

Authorization to Pay & Release Medical Records

Our office will bill your insurance. It is your responsibility to understand your insurance plan and coverage details. You are responsible for the deductible, co-insurance, co-payment at time of visit, and any costs not covered by your insurance company. If you do not have insurance we require payment at the time of your visit. Our staff is available if you have any questions or concerns. Fall General Surgery LLC reserves the right to withhold overpayment refunds less than or equal to $5.00.

I authorize payment of medical benefits be made directly to Fall General Surgery, LLC for services rendered. I authorize release of any information concerning my (or my dependent's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize use of information from this form to bill my insurance companies.

Sign Here _____ _____

Signature of patient (or parent/guardian if patient is a minor) **Date**