Colon and Rectal Clinic

Roger W. Hsiung, M.D., F.A.C.S., F.A.S.C.R.S.
Calvin D. Lyons, M.D., F.A.C.S., F.A.S.C.R.S.

PATIENT REGISTRATION FORM

PRINT IN BLACK INK ONLY

(Please Print)

PATIENT INFORMATION

Last Name _____ **First Name** _____ **M.I.** _____ **DOB** ____/____/____

Home Mailing Address _____ **APT#** _____

City _____ **State** _____ **Zip Code** _____ **Email:** _____

Home Phone # ( ) _____ **Cell Phone # ( )** _____

Social Security Number ____ - ____ - ____ **Marital Status :** □ **Married** □ **Single**

Employer _____ **Referred By(Doctor,Friend,Etc.)** _____

Emergency Contact _____ **Phone #** _____

Nearest Friend or Relative _____ **Phone #** _____

CURRENT PHARMACY INFORMATION

Name _____ **Phone #** _____

Address _____

Street Address

_____

City *State* *Zip Code*

INSURANCE INFORMATION

Primary Insurance **Effective Date** ___/___/___ **Term Date** ___/___/___

Insurance Name _____

Phone No. _____

Address _____

City _____ **St / Zip** _____

Policy # _____

Policy holder's Name _____

Group # _____

Relationship _____ **DOB** _____

SSN of Insured ____ - ____ - ____

Employer _____

Secondary Insurance **Effective Date** ___/___/___ **Term Date** ___/___/___

Insurance Name _____

Phone No. _____

Address _____

City _____ **St / Zip** _____

Policy # _____

Policy holder's Name _____

Group # _____

Relationship _____ **DOB** _____

SSN of Insured ____ - ____ - ____

Employer _____

PATIENT SIGNATURE **DATE**

Colon and Rectal Clinic

Patient Name: _____ Age: _____ Date of Visit: _____

Height: _____ Weight: _____Temp:_____BP:_____HR:_____

PREVIOUS ILLNESSES (Please list any illnesses you have had and the dates of the occurrences)

_____ _____

_____ _____

_____ _____

PREVIOUS COLON SCREENING (Please list the most recent colon screenings you have undergone including the procedure dates)

☐ Flexible Sigmoidoscopy _____ ☐ Colonoscopy _____

☐ Barium Enema_____ _____

PAST SURGICAL HISTORY (Please list all operations you have had and the dates of occurrences)

_____ _____

_____ _____

_____ _____

_____ _____

MEDICATION (Please list all medications that you are currently taking including the dose you take. Please include over-the-counter supplements and herbal medications)

_____ _____

_____ _____

ALLERGIES (Please list any medication you are allergic to and explain the reaction to the medication

☐ No Known Drug Allergies _____ _____

_____ _____

FAMILY HISTORY (Please list your family member and the appropriate disease)

☐ Colon Cancer _____ ☐ Other _____

☐ Rectal Cancer _____ _____

☐ Polyps _____ _____

REVIEW OF SYSTEMS (Have you had or do you currently have a history of any of the following? Please check all that apply.)

General	**Cardiovascular**	**Urologic**	**Female Reproductive**	**Neurologic Psychiatric**
☐ Recurrent fever	☐ High blood pressure		☐ Irregular menstruation	☐ Stroke
☐ Significant weight change	☐ Irregular heart beat	☐ Frequent urination	☐ Vaginal spotting	☐ Seizure
	☐ Heart murmur	☐ Blood in urine	☐ Vaginal discharge	☐ Fainting or blackouts
	☐ Heart attack	☐ Urinary incontinence	☐ Ovarian cysts	☐ Anxiety
Eye, Ear & Throat	☐ Abnormal heart value		☐ Endometriosis	☐ Phobia
☐ Cataracts	☐ Swollen feet	**Male Reproduction**	Enter number of previous	☐ Depression
☐ Glaucoma	☐ Abnormal stress test	☐ Prostate gland	pregnancies:	
☐ Retinopathy	☐ Pacemaker	problems		**Personal Habits (circle)**
☐ Sinus problems	☐ Blood thinner use	☐ Abnormal PSA	**Respiratory**	Do you smoke?
☐ Dental problems	☐ High cholesterol	☐ Difficulty urinating	☐ Sleep apnea	Yes ☐ No ☐
☐ Bleeding gums		☐ Penile discharge	☐ Productive cough	Do you drink alcohol?
☐ Hoarseness	**Abdominal/GI**	☐ Testicular pain/mass	☐ With sputum	Yes ☐ No ☐
☐ Recent sore throat	☐ Hernia		☐ Shortness of breath	
☐ Difficulty swallowing	☐ Nausea/Vomiting	**Endocrine**	☐ Asthma	**Other**
	☐ Reflux	☐ Diabetes	☐ Wheezing	
Hematologic	☐ Peptic Ulcer	☐ Thyroid problems		
☐ Anemia	☐ Jaundice	☐ Hormonal	**Rheumatologic**	
☐ Blood Disorder		abnormalities	☐ Back pain	**Primary Care Doctor**
	Dematologic	☐Steroid use	☐ Joint pain	
Oncology	☐ Rash		☐ Joint swelling	**Other Physicians**
☐ Chemotherapy	☐ Skin cancer		☐ Arthritis	
☐ Radiation				

Encounter Time: _____mins Counsel Time:_____mins

I have reviewed the above information with the patient on this date. All boxes which are not checked are either negative or N/A

Physician's Signature _____ Date _____

RECORDS RELEASE AUTHORIZATION

THIS FORM IS IF YOU NEED US TO GET ANY RECORDS FROM ANY OTHER DOCTORS OFFICE

TO: _____

I hereby request that you release my medical records to:

Colon and Rectal Clinic

Roger W. Hsiung, M.D.
Calvin D. Lyons, M.D.

6080 S Durango Dr. Suite 105
Las Vegas, NV 89113
Phone: (702) 586-6688
Fax: (702) 586-9988

A report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me from dates:

_____to_____

_____ _____
Date of request Patient's name

_____ _____
Date of birth Social security number

Patient's signature: _____

Colon and Rectal Clinic

Roger W. Hsiung, M.D., F.A.C.S., F.A.S.C.R.S.
Calvin D. Lyons, M.D., F.A.C.S., F.A.S.C.R.S.

6080 S Durango Drive, Suite 105
Las Vegas, NV 89113
Phone: (702) 586-6688
Fax: (702) 586-9988

Authorization for Use and Disclosure of Protected Health Information

THIS FORM IS FOR A LIST OF ANY FAMILY MEMBERS OR FRIENDS THAT HAVE PERMISSION TO ACCESS YOUR RECORDS OR INFORMATION

I hereby consent to release my medical records to the following individuals only:

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

Colon and Rectal Clinic

Roger W. Hsiung, M.D., F.A.C.S., F.A.S.C.R.S.
Calvin D. Lyons, M.D., F.A.C.S., F.A.S.C.R.S.

Payment for office visit and office procedures

I understand my services at our office will usually consist of separate charges for **1) the office visit**, **2) diagnostic procedures** (which may include an anoscopic, proctoscopic and/or flexible sigmoidoscopic examination), **and 3) any treatment rendered**. Even though these services are provided within our office, some insurance carriers consider the anoscopic, proctoscopic, flexible sigmoidoscopic examinations, and certain treatments as "procedures" and may subject these services to a separate deductible rather than to your "co-pay".

In this event, I agree to make payment **upfront** for both office consultation and office procedures

I understand that the payment quoted beforehand is an estimate, a balance may occur on your account. The final amount is determined upon the completion of the procedures and solely based on my insurance coverage.

Penalty agreement for office visit

If Cancellation of my appointment becomes necessary, I shall cancel my appointment no later than **24** hours prior to scheduled appointment time. I understand that if I fail to cancel in advance, I will personally be billed **$40.00** and such charge will not be payable through my insurance.

Payment method

- I understand that checks are **NOT** accepted for the payments that are made upfront. They will be accepted for balance on account.

Other office charges

- I am aware that there is a **$40.00** Charge for any returned checks.
- I understand that there is a **$40.00** Charge for any family Medical Leave Act Papers to be filled out
- I understand that there is a charge of **$2.00** per report for medical record request

_____

(PRINT NAME) (PATIENT SIGNATURE) (DATE)

Colon and Rectal Clinic

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Calvin D. Lyons, M.D., F.A.C.S., F.A.S.C.R.S.

Penalty Agreement for Surgery

1. If cancellation of my surgery appointment becomes necessary I shall cancel my surgery appointment no later than **48 hours** prior to scheduled appointment time. I understand that if I fail to cancel in advance I will be personally penalized **$200.00** and such charge will not be payable through my insurance.

2. I understand I will be penalized **$200.00** when I do not show up for my surgery appointment.

Surgery Payment agreement

1. I understand that the payment I made upfront is just an estimate. The accurate amount of the payment will be given when the claim is successfully filled by my insurance, and I am financially responsible for any remaining balance.

2. I understand that it will lead to the cancelation of the surgery if I fail to make the payment prior to the surgery.

3. I understand that my insurance can deny my claim for different reasons such as any pre-existing conditions, benefits not covered by them, or other reasons deemed by them, and I am financially responsible for any claim denied by my insurance.

Patient Print name: _____

Patient Signature: _____

Date: _____

Colon and Rectal Clinic

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Prescriptions

We require 24-72 hours to process your prescription refills. This 24-72 hours excludes weekends and holidays. If you are running low on your medications please call ahead of time to allow us the proper amount of time to refill your prescriptions.

Telephone Messages

Any urgent messages that we receive will be answered as soon as possible. For all other messages received, we will try to address them by the end of the day, otherwise, it will be first thing in the morning.

(Print Name) (Signature) (Date)

COLON AND RECTAL CLINIC | FINANCIAL POLICY

Please read this policy carefully. If you have any question regarding our policy, please speak with our staff.

If we participate with the patient's insurance plan, we will file an insurance claim on their behalf, and collect any out-of-pocket expenses at the time services are rendered to the patient. Out-of-pocket expenses include co-payments, co-insurance, and deductibles. We will estimate the patient's out-of-pocket expenses as closely as possible based on the fee schedule provided by the insurance company. If the insurance company has not provided their fee schedule to our office, we will estimate a discount based on the average discount of all of our insurance contracts.

We will file claims on behalf of the patient to both the primary and secondary insurance carriers as applicable. If the insurance carrier(s) requests additional information from the patient, it is the responsibility of the patient to respond in a timely manner in order for the insurance company to process services rendered within the time frame allowed. Failure to provide requested information to the insurance company may result in your claim being pended or denied, and 100% of the total charges will become patient responsibility.

Although every effort will be made to estimate the patient's actual out-of-pocket expenses, the insurance company may process the claim differently than we originally estimated. After the charges for services rendered are processed by the insurance company(s) and all payments and discounts are applied, our office/billing company will then send the patient a notification by mail of any further balance due. Any balance that is considered patient responsibility after insurance has processed the claim is due within 30 days. If extended payments are needed on large balances, our patient account representatives are available to discuss payment plan options with the patient. If the patient has an overpayment balance, we will then issue a refund to the patient within 30-90 days of receipt of the insurance company determination.

REFERRAL/AUTHORIZATIONS

- ***REFERRALS*:** Patient cooperation is necessary in obtaining the proper referral/authorization. If a patient's insurance company requires a referral/authorization prior to the patient being seen, it is the responsibility of the patient to verify with the office that all proper documentation has been received. Please be advised that if the patient elects to be seen without a valid referral/authorization, have changed Primary Care Providers without obtaining a new referral/authorization, or patient referral/authorization expires, the services will be considered non-covered under your HMO/POS. If one of the above-mentioned incidents should happen, the patient will then be responsible for payment of all charges and no discount will be applied. If out-of-network benefits are available under the patient's policy, the patient will be responsible for paying the amount due (which will most likely be higher balance than if a referral/authorization was obtained). Please be advised that the referral/authorization obtained for the patient to be treated by Colon and Rectal Clinic will not cover other patient services rendered outside of the Colon and Rectal Clinic office; the patient may receive separate bills for any services rendered outside of this office by the providers and/or facility of those services (ie. lab work, radiological testing, anesthesia, or other facility services).
- ***AUTHORIZATIONS*:** The Colon and Rectal Clinic office staff will make every effort for ensuring that any prior authorization for all procedures performed, in our office or at an outside facility, is obtained prior to services being rendered. Patient cooperation to verify that authorization has been obtained is recommended. In the event Colon and Rectal Clinic is unable to obtain prior authorization from the insurance carrier, we reserve the right to postpone and/or cancel your procedure until such time that prior authorization can be obtained. In the event the patient continues to proceed with any scheduled procedure and Colon and Rectal Clinic has not been able to obtain prior authorization for that procedure, the patient will be asked to sign documentation indicating that they have been advised of our inability to obtain prior authorization and that the patient will be accepting full responsibility for all cost involved for services rendered. Most insurance carriers no longer provide retro-authorizations for scheduled procedures. Please be advised that this may also include charges for services at the facility where the services are rendered.

PROCEDURAL SERVICES

Services at our office typically consist of the following charges; 1) office visit, 2) diagnostic procedures (which may include an anoscopic, proctoscopic and/or flexible sigmoidoscopic examination), and 3) any procedures rendered. Even though these services are provided within our office, some insurance carriers consider the anoscopic, proctoscopic, flexible sigmoidoscopic examinations, and certain treatments as "procedures" and these services may be subject to a separate co-pay, co-insurance, and/or deductible (in addition to the office visit "co-pay"). Should the above mentioned occur, the patient may receive a bill for the portion of any co-pay, co-insurance, and/or deductible and will be responsible for payment of the amount due after the insurance contract discounts have been applied.

PRE-EXISTING CLAUSES

Patient's insurance plan guidelines may include a pre-existing clause, which states that the insurance company will not pay for treatment of certain conditions that have been previously treated for up to a specific length of time prior to the patient's effective date of coverage. If the policy includes a pre-existing clause, and the insurance company subsequently investigates the claim and determines the services rendered to be non-covered, the patient will be responsible for payment of services. It is patient responsibility to determine if their insurance plan has any pre-existing clauses.

COLLECTIONS AND AGENCY FEES

If a patient account balance is more than 90 days past due, Colon and Rectal Clinic reserves the right to turn the patient account over to the collection agency of our choice and will be permitted to add additional penalties up to and including all collection agency fees and costs associated with your account going to collections. Please be aware that if the patient's account is turned over for collections, all outstanding balances owed to Colon and Rectal Clinic must be paid in full prior to the scheduling of any further office visits and/or procedures.

PATIENT AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I, (*PLEASE PRINT PATIENT NAME*) _____ authorize the release of any medical or patient information necessary to process my claim(s). I also authorize payment of insurance medical benefits to Colon and Rectal Clinic for all outstanding services rendered to me.

BY SIGNING BELOW, I HAVE READ AND AGREE TO ABIDE BY THE TERMS OF THE COLON AND RECTAL CLINIC FINANCIAL AGREEMENT.

_____ _____

Signature of patient/Responsible Party **Date**

Colon and Rectal Clinic

Roger W. Hsiung, M.D., F.A.C.S., F.A.S.C.R.S.
Calvin D. Lyons, M.D., F.A.C.S., F.A.S.C.R.S.

PATHOLOGY FINANCIAL POLICY

When a physician performs a surgical procedure, several healthcare providers (i.e. the surgery center staff, anesthesiologist, radiologist, and pathologist) may participate in your care. These independent providers bill your insurance separately for their services. If you receive a bill from a laboratory (MedLab, Quest Diagnostics, LMC, etc.,) it is because they have provided diagnostic pathology services to your physician on your behalf, and your insurance may not have agreed to pay the full amount.

Self pay patients are billed at the Medicare rate per specimen. Different specimens involve different amounts of work in terms of grossing, microscopic examination and reporting the diagnosis by the pathologist. The American Medical Association has determined the following codes are to be used on professional claims to specify the amount of service rendered. The pathology CPT code(s) are adjacent to the pathologist signature at the end of every pathology report. The following are what you can expect to be billed per specimen.

CPT Service Code	Patient is billed	As example
88304	$62 per specimen	Anal tag, colostomy stoma, hemorrhoid, pilonidal cyst/sinus
88305	$104 per specimen	Biopsy of : esophagus, stomach, duodenum, small bowel, colon, rectum
88312*	$100 per special stain	Infectious organism identification
88342*	$100 per HIC stain	Cancer cell type

(Prices provided by MedLab)

- Additional testing used in some special circumstances, to rule out or confirm an infection or cancer diagnosis.

Please note that your surgeon might obtain more than one specimen depending on your medical condition.

For patients experiencing financial hardship, most labs offer payment plan options. Please contact the lab to make arrangements.

Patient Name: _____ Date: _____

By signing the document, I acknowledge that I have read and understand its contents:

Patient/ Patient Representative Signature: _____

IF THIS FORM IS MODIFIED IN ANY WAY, THE ENTIRE FORM WILL BE VOID. OUR OFFICE RESERVES THE RIGHT TO DENY TREATMENT TO ANYONE IF THIS FORM IS NOT SIGNED.

(If you would like a copy of this form, please feel free to ask the receptionist.)

1. Authorization to Release Information: I hereby authorize the physician to release any information required by my insurance company or another doctor or hospital, acquired in the course of my examination or treatment.

2. Authorization to pay benefits to Physician: In consideration of services rendered I the undersigned patient, do hereby irrevocably assign and transfer to my provider Dr. Roger W. Hsiung all benefits due me whether contractual, statutory, or common law.

3. I consent to any medical treatment deemed medically necessary by the provider. I understand that prior to any treatments being rendered, the treatment will be discussed with me and all questions will be answered.

4. Patient care and confidentiality is our priority. We will not release or disclose any of your personal health information to anyone. We will not release any information to a parent, spouse, significant other, friend, relative, or translator. If you would like to sign an "Authorization of Use and Disclosure of Protected Health Information" form, please ask the receptionist. This form will authorize us to release or speak to your parents, spouse, significant other, family, friend, or translator regarding your personal healthcare.

5. We are contracted with most insurance companies, but please check with your insurance company to be certain that we are providers.

6. Please do not assume that your insurance will pay for services just because we obtained prior authorization. Your insurance can deny your claim for pre-existing conditions, benefits not covered by them, or other reasons deemed by them. You will be responsible for any claim denied by your insurance.

7. Almost all lab testing done in the office, including pap smears, will be sent out and billed by the lab.

8. I understand that Dr. Roger W. Hsiung will bill my insurance as a courtesy to me. If payment is not received within 120 days from the date of billing, I will be made financially responsible for any and all services rendered. Should this account have to be turned over to a collection agency, I agree to pay all collection and legal fees necessary to collect the balance on my account. The outside collection agency will add a 25% collection fee to any amount we turn over to them. Legal fees may also be added.

9. Please be advised and understand that this office can only code and file a claim for your visit(s) with a diagnosis that is encountered and documented in your medical record. Thus, to ask this office to change a diagnosis for the sole purpose of securing reimbursement from an insurance carrier is inappropriate and could result in a fraudulent act. For example, once we file your claim as a preventative exam, we cannot reprocess your claim as a "sick visit" for the sole purpose of securing reimbursement by your insurance company.

10. There is a $40.00 fee for any returned checks.

11. I authorize Colon and Rectal Clinic to obtain my medication history.

PATIENT SIGNATURE_____**DATE**_____

Colon and Rectal Clinic

Roger W. Hsiung, M.D., F.A.C.S., F.A.S.C.R.S.
Calvin D. Lyons, M.D., F.A.C.S., F.A.S.C.R.S.

ANORECTAL SURGERY & OFFICE TREATMENT PROCEDURES

INFORMED CONSENT

You and your doctor are considering a surgical procedure on the anus or rectum. This is when the doctor performs a surgical treatment to help correct a problem that is occurring in this area. Your doctor can make no guarantee that your problem will be either corrected or cured by this procedure.

Anorectal surgery is by definition, not considered major surgery, and therefore is not assigned the higher level of risk that major surgery entails. Although anorectal surgery is by definition minor surgery, it can be a big or small procedure relatively speaking. The bigger and more complicated the procedure, the larger the risk.

By signing this form, you are authorizing your physician to do whatever he deems to be advisable in your interest. Without your prior knowledge, if any unforeseen condition arises during the surgery, your physician may call for additional diagnostic tests, procedures, operations or medication (including anesthesia and blood transfusion), for which there is specific indication or need. In the event that medical personnel should inadvertently get stuck with a sharp instrument and/or contaminated with your blood, your blood may be tested for infectious diseases, including HIV.

The length of treatment may vary per each individual, and the extent of any surgery necessary cannot always be determined in advance of an operation. Depending upon your circumstances, it is possible that you may have several surgical operations or treatments over the upcoming weeks to years.

Your doctor may travel occasionally, and may be unavailable to you in the event of an emergency situation. In the event of an emergency, which is any condition listed on this form, you may need to follow up with care for your surgical procedure with another physician who is on call, or you may have to go to the nearest emergency room for care and treatment.

Complications from anorectal surgery rarely occur. If they do, most are corrected easily.

Bleeding- It is possible to lose more blood than usual or anticipated during and after a surgical operation. But only in rare cases will a blood transfusion ever be necessary.

Allergy- Taking the pharmaceutical, nutritional, and/or botanical nutraceuticals prescribed by your physician have been shown to minimize the negative effects of medications and

anesthesia. However, it is still possible to have a life threatening reaction to one or more of the medications, including to the anesthesia that you will receive during the course of your treatment.

Urinary Retention- If this occurs, it is usually associated with anal muscle spasm after surgery, and/or enlarged prostate. This problem improves quickly during recovery. However, in extreme cases or urinary retention, a catheterization(s) by a home health nurse may be indicated.

Rectal Stenosis- A common complication that can occur from rectal surgery is a tightening of the anal canal with the formation of excess scar tissue. This condition is easily corrected using a simple procedure to modify scar tissue using dilation. It's possible for this to become a chronic and recurrent condition after treatment.

Infection- Proper adherence to a prescribed diet, adequate hydration, exercise, rest, and a proper mental attitude helps your immune system function at its highest level. However, it is still possible for the postoperative site not to heal completely. Sometimes, the body does not have the ability to resist infection in the surgical wound site. This infection can form a chronic sore, localized abscess draining pus, crack or fissure, and in some instances, cause the whole body to become very sick. Rarely is this condition life threatening.

Fecal Incontinence- This is the failure of voluntary control of the anal sphincter muscles, with involuntary passage of stool or gas. This condition is rare, but can happen.

In addition, it is possible to have unforeseen complications that are not listed here. Some of the complications from this procedure may require major surgery, blood replacement therapy; and can cause poor healing wounds, permanent disability, permanent deformity, and/or scarring. Very rarely are these complications fatal.

Furthermore, there may be alternatives to this procedure available to you, such as repeated local injections to the problem area, or the use of rectal suppositories and other medicines. However, these alternative methods carry their own risk of complications and a varying degree of success. Therefore, in those patients in whom anorectal surgery is indicated, the procedure provides the patient with the best chance of successful treatment and the lowest risk of complications.

I CERTIFY THAT I HAVE READ OR HAD READ TO ME THE CONTENTS OF BOTH PAGES OF THIS FORM. I UNDERSTAND THE RISKS AND ALTERNATIVES INVOLVED IN THIS PROCEDURE. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS WHICH I HAD AND ALL WERE ANSWERED.

SIGNED_____ **DATE**_____

WITNESS_____ **TIME**_____

HIPAA NOTICE OF PRIVACY PRACTICE

COLON AND RECTAL CLINIC

Roger W. Hsiung, M.D.
6080 South Durango Drive, Suite #105
Las Vegas, NV 89113
Phone (702)586-6688 Fax (702)586-9988

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION: Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your case and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use disclosed your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example we would disclose your PHI, as necessary, to a home health agency that provides care to you. Your PHI may be provided to whom you have been referred to ensure that the physician has the necessary information diagnose or treat you.

PAYMENT: Your PHI will be used, as needed, to obtain payment for your healthcare services. For example obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities included, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may also use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situation without your authorization. These situations include: As Required by Law; Public Health Issues as required by law; Communicable Disease; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required Uses and Disclosures, under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES: will be made only with your consent authorization, or opportunity to object unless by law.

YOU MAY REVOKE THIS AUTHORIZATION: at any time, in writing, except to the extent that your physician or the physician's practice has taken and action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS: The following is a statement of your rights with respect to your PHI.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PHI: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PHI: This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restricting to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AN ALTERNATIVE LOCATION. YOU ALSO HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US: upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

YOU MAY HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PHI: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURS WE HAVE MADE, IF ANY, OF YOUR PHI: We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS: You may complain to us or to Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices:

PRINT NAME:_____

SIGNATURE:_____ DATE: _____

Colon and Rectal Clinic

Roger W. Hsiung, M.D., F.A.C.S., F.A.S.C.R.S.
Calvin D. Lyons, M.D., F.A.C.S., F.A.S.C.R.S.

A BRIEF LOOK AT ARBITRATION FOR THE PATIENT

Introduction
Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as the California Medical Association, and noted to be a favored method of resolving disputes by the United States Supreme Court.
If you are unfamiliar with arbitration in general the information included here provides some of the basic principles of arbitration.

What is Arbitration?
Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and expensive process of court litigation, you and the doctor agree in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among the numerous retired judges who are available and qualified to serve on these matters, and is mutually agreed upon by both you and the doctor. After a hearing, which is usually less formal than a court proceeding, the arbitrator makes the decision ("award"). Although the procedures are different, generally the same laws and same measure of damages which apply in court proceedings also apply in arbitration.

Does arbitration prevent you from making a claim?
No. By selecting arbitration as the means to resolve a disagreement all you are essentially doing is moving the claim to a different forum(i.e., from a jury to an arbitrator) to hear and ultimately decide your claim.

Does it prevent you from obtaining a financial award?
No. Arbitration does not restrict or prevent you from obtaining a financial award in any manner. If the arbitrator accepts and agrees with your claim he will determine a damage award. The United States Supreme Court has, in fact, previously held that arbitration is strongly favored as an expeditious and economical alternative to the court system.

May I be represented by an attorney of my choice?
Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrator will hear the facts and decide the matter whether or not the parties are represented by lawyers.

Who is bound by this agreement?
If you choose to sign the arbitration agreement you will be agreeing to bind yourself and anyone who could bring suit in connection with treatment or services provided to you by the doctor. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could sue in connection with treatment or services provided to that person by the doctor. Likewise, the doctor or any one suing on behalf of a doctor, is bound.

What does arbitration cost?
In general, arbitration is less expensive than court actions. The arbitrator's fees are ordinarily shared equally by the parties. The amount of those fees will depend upon the complexity and length of the case.

If either party does not like the arbitration results could there still be a jury trial in court?
Generally the answer is "no". The whole purpose of arbitration is to avoid the expense, delay and inconveniences of going to court. Arbitration awards may be reviewed, and potentially reversed ("vacated") by a court in limited circumstances.

A Message to Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you received is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the courts.
By signing this agreement you are changing the place where your claim will be presented. You may still call witness and present evidence. The case is heard by a single arbitrator. This agreement generally helps to limit the legal cost for both patients and physicians. Further, both parties are spared some of the rigors of trials and publicity that may accompany judicial proceedings.
Our goal of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

PHYSICAL PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any disputes as to medical malpractice, that is to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission or arbitration as provided by Nevada Law, and not by a lawsuit or resort to court process except as Nevada Law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics and or providers(hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician by any action in any court by the physician to collect any fee from the patient shall no waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a Physician, including any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. Mail, postage prepaid, to all parties, describing the claim against the Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall therefore select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada revised Statutes (NRS) 38.206-382.48, 41A.035, 0.045, 0.097, 0.100, 0.110, 0.120, 42.005 and 0.021 and the Federal Arbitration Act (9 U.S.C §§ 1-4), and that they have the absolute right to arbitrate separately the issue of liability and damages upon written request to the arbitrator. The parties shall bear their own cost, fees and expenses, along with a pro rated share of the neutral arbitrators fees and expense.

Article 4: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Nevada and Federal law

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ **INITIAL HERE TO INDICATE THAT YOU HAVE BEEN GIVEN THE DOCUMENT TITLED**
Initials **"A BRIEF LOOK AT ARBITRATION FOR THE PATIENT"**

By:_____ _____
Physician or Duly Authorized Representative Signature — Date

By:_____ _____
Patients Signature — Date

By:_____
Print or Stamp name of Physician, Medical Group or Association Name

By:_____
Print Patients Name

By:_____ _____
Signature of Translator (if applicable) — Date

By:_____ _____
Patients Representatives Signature (if applicable) — Date

_____
Print Name of Translator

_____
Print Name and Relationship To Patient

A signed copy of this document is to be given to the patient. The original is to be filed in the patient's medical records.

Colon and Rectal Clinic

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Controlled Substance Agreement

INFORMED CONSENT FOR THE PRESCRIPTION OF CONTROLLED SUBSTANCES

Patient: _____

Provide: DR. ROGER W. HSIUNG, M.D., F.A.C.S., F.A.S.C.R.S.

Medications: NARCOTICS

In accordance with Nevada law AB 474, prior to giving me a Controlled Substance prescription, my provider is required to obtain my written Informed consent.

My provider has explained to me that these medications may include opioids and/or other drugs that can be used to treat pain, anxiety, insomnia, attention deficit disorder, depression and other conditions. I understand that these medications have known risks and side effects, and can be harmful if taken without medical supervision. I further understand that taking these medications can lead to tolerance, physical dependence, and/or developing an addictive disorder. Stopping the medication abruptly may lead to withdrawal symptoms and/or psychological dependence or addiction that is an abnormal psychological craving of the medication to the point of becoming a danger to oneself or others.

I understand that the most common side effects that can occur with the use of these medications include but are not limited to:

- Constipation
- Nausea/vomiting
- Excessive drowsiness or sleepiness
- Itching
- Urinary retention (inability to urinate)
- Low blood pressure
- Irregular heart rate
- Inability to sleep
- Depression
- Impaired judgment and/or reasoning
- Respiratory depression (slow or no breathing)
- Impotence
- Tolerance to medications
- Physical or psychological dependence
- Addiction
- Death

I further understand that it may be dangerous for me to operate a motor vehicle or other machinery while taking these medications.

The risks, benefits and alternative treatments, including their risks and benefits have been explained to me. I understand that not every possible risk and benefit is listed on this form and that this consent includes the most common side effects or reactions. I acknowledge that I have been warned about the dangers of overdose and/or combining the prescribed medications with other drugs or alcohol may cause serious illness or death.

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Controlled Substance Agreement

INFORMED CONSENT FOR THE PRESCRIPTION OF CONTROLLED SUBSTANCES

For Female patients in child bearing age

I understand that there are unknown side effects of the prescribed medications that could harm an unborn child. If I am not pregnant, I will use appropriate contraception (birth control) during the course of my treatment. If I become pregnant or am uncertain, I will notify my provider immediately.

For Minors
I have been informed of the risks that my child may abuse, misuse or divert these controlled substance medications. I have been informed of the ways to detect such misuse.

In addition I have been informed of

- Proper use storage and disposal of these medications
- How refills will be addressed
- If the medication is an opioid, I understand that I can get the medication to counteract its effects (an opioid antagonist) without a prescription

The goal of this treatment is for the management of my current medical condition. I understand that my treatment plan will be tailored for me. I further understand that I may withdraw from this treatment plan and discontinue mediation use at any time. I understand that prior to doing so I need to inform my provider since there may be a medical risk associated with abrupt termination of these medications.

I have been given an opportunity to ask questions about my condition and treatment and the risks and benefits of the prescribed controlled substance(s).

I authorize and direct my provider to prescribe controlled substance(s). I understand in order to initiate or continue treatment with controlled substances I must agree to the condition set forth above.

_____ _____ _____
Signature of Patient/ Authorized Representative Date Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications and alternatives to the prescribed medications to the patient or patient's legal representative. I have answered all questions fully and I believe the patient/legal representative fully understands what I have explained.

_____ _____ _____
Provider Signature Date Time