AARON S. BRANSKY, MD, PA

6309 PRESTON ROAD, SUITE 1200 PLANO, TEXAS 75024 ▪ 972-612-3965 ▪ FAX 972-618-4219

HIGH QUALITY SURGICAL CARE FOCUSED ON YOU!

My goal is to make you feel like you're my only patient. I focus on you individually and provide a thorough education and understanding of your condition, options for treatment, and details of your surgery. I don't employ residents to conduct or assist with cases.

Comprehensive post-operative care is stressed and completed by me - not a Physician Assistant. Only in rare cases do I rely on another board certified surgeon to cover my patients. I'm truly focused on you, and have the skills and experience needed to deliver the quality of care you deserve.

POST OPERATIVE APPOINTMENT

It's critical that you keep your post operative appointment. During this visit Dr. Bransky will remove any sutures, check on the healing process, ensure there is no evidence of infection, and provide an update on restrictions, among other things. There is no additional charge for this visit.

If you need to reschedule your appointment, please contact Dr. Bransky immediately.

NEW PATIENT REGISTRATION

Please bring a Driver's License or other government issued ID, your insurance card(s), and the following completed forms to your appointment:

- Patient Information
- Patient Medical History
- Financial Policy & Agreement
- Assignment of Benefits (insured patients only)

THE OFFICE

The office is located on the West side of Preston Road slightly North of W. Spring Creek Parkway. Specifically, the office complex is located between the Marriott Residence Inn and 7-11 on the West side of the street.

If you need directions please see our website at www.drbransky.com or contact the office.

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PATIENT INFORMATION FORM

PATIENT DEMOGRAPHICS

PATIENT NAME: LAST _____ FIRST _____ M.I. _____ AGE _____

BIRTH DATE _____ SOCIAL SECURITY # _____ - _____ - _____ MARITAL STATUS _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ EMAIL ADDRESS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMPLOYER _____ LOCATION _____

SPOUSE'S NAME: LAST _____ FIRST _____ M.I. _____

BIRTH DATE _____ SOCIAL SECURITY # _____ - _____ - _____

WORK PHONE _____ CELL PHONE _____

INSURANCE

Please Note: A copy of the front and back of your card(s) may be provided in place of completing this section

PRIMARY INSURANCE _____

ADDRESS _____

POLICY # _____ GROUP # _____ GROUP NAME _____

SECONDARY INSURANCE _____

ADDRESS _____

POLICY # _____ GROUP # _____ GROUP NAME _____

IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____

ADDRESS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient or Legal Guardian Signature	Print Patient Name or Legal Guardian	Date

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PATIENT MEDICAL HISTORY FORM

PATIENT NAME: LAST _____ FIRST _____ M.I. _____

MEDICAL CONDITIONS

Please list any past medical problems, even if corrected with current medications:

_____ _____ _____

_____ _____ _____

SURGICAL HISTORY / TRAUMA HISTORY

Please list all operations or injuries you have had:

DESCRIPTION	MONTH / YEAR	HOSPITAL

Have you or any family members ever had a reaction to anesthesia? _____ **Bleeding problems?** _____

MEDICATIONS

List current medications including non-prescription items (e.g. Dietary Supplement, Diet Pills, Cold & Flu Medications, etc.)

NAME	DOSAGE & FREQUENCY	REASON

Have you taken any of the following in the last month? Prednisone _____ Coumadin _____ Aspirin/Motrin/Naprosyn _____

Please list medications to which you are allergic: _____

REVIEW OF SYSTEMS

Please check the box if you are currently experiencing a symptom

☐ Fevers	☐ Ankle Swelling	☐ Vomiting	☐ Breast Lump / Pain
☐ Fatigue	☐ Calf Pain	☐ Upper Abdominal Pain	☐ Nipple Discharge
☐ Weight Changes	☐ Shortness of Breath	☐ Lower Abdominal Pain	☐ Headache or Migraines
☐ Vision Changes	☐ Sob with Exertion	☐ Jaundice	☐ Dizziness
☐ Hearing Loss	☐ Irregular Pulse	☐ Painful Urination	☐ Room Spinning
☐ Ringing in Ears	☐ Wheezing	☐ Blood in Urine	☐ Seizures
☐ Ear Pain	☐ Cough/Sputum	☐ Straining on Urination	☐ Passing Out
☐ Bloody Nose	☐ Coughing Blood	☐ Kidney Stones	☐ Numbness or Tingling
☐ Nasal Discharge	☐ Diarrhea	☐ Pelvic Pain	☐ Memory Loss
☐ Sinusitis	☐ Constipation	☐ Vaginal Discharge / Bleeding	☐ Anxiety
☐ Sore Throat	☐ Stool Incontinence	☐ Joint or Muscle Pain	☐ Depression
☐ Hoarseness	☐ Black Tarry Stool	☐ Decreased Mobility/Weakness	☐ Suicidal Thoughts
☐ Oral Ulcers	☐ Bloody Stool	☐ Joint Swelling / Skin Rash	☐ Excessive Thirst
☐ Chest Pain	☐ Difficulty Swallowing	☐ Itching	☐ Excessive Urination
☐ Palpitations	☐ Heartburn	☐ Mole Change	☐ Easy Bruising
☐ Swollen Nodes	☐ Nausea	☐ Loss of Hair / Brittle Nails	☐ Bleeding Tendency

SOCIAL HISTORY

Marital Status _____ Number of Children _____ International Travel? _____

Occupation _____ Do you do heavy lifting on a daily basis? _____

Cigarette Smoking _____ Current _____ Past No of Packs per Day _____ Drug Use? _____

Alcohol Intake _____ None _____ Occasional _____ 1-2 drinks per day _____ More than 2 drinks per day

FAMILY HISTORY

Check the box if you have a first degree relative (parent or sibling) with the following conditions:

Breast Cancer _____ Ovarian Cancer _____ Skin Cancer _____ Lymphoma _____ Leukemia _____ Inflammatory Bowel Disease _____

Brain Tumors _____ Heart Disease _____ Thyroid Disease _____ Parathyroid Disease _____ Other _____

The undersigned has carefully and fully reviewed the information provided and acknowledges it is complete to the best of my knowledge.

_____ _____ _____

Patient or Legal Guardian Signature | Print Patient Name or Legal Guardian | Date

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FINANCIAL POLICY & AGREEMENT

PATIENT NAME: LAST _____ FIRST _____ M.I. _____

This practice will provide medical services to all patients regardless of insurance coverage. This policy serves to assist you in understanding your financial obligations to this practice.

INSURANCE

This practice accepts all forms of insurance and works with all major insurance plans *except Medicaid*. However, this practice is not a contracted medical provider under any insurance programs except Medicare and Worker's Compensation. Therefore, we must emphasize that your policy is an agreement between you and your insurance company. All charges for our medical services remain strictly your responsibility from the date services are rendered.

A claim for all services performed by Dr. Bransky will be submitted to your insurance carrier whether or not we participate in your particular plan. All insurance companies have a schedule of fees (i.e. allowable, usual and customary, in network, etc.) specific to your particular plan based on which they will pay a claim in whole or in part. The fees charged by this practice may be more than what the insurance company provides. Therefore, any balance not covered by the insurance company, including but not limited to co-payments, deductibles, and co-insurance, remains the responsibility of the patient. We do not consider payment from your insurance company as payment in full.

UNINSURED AND MEDICAID PATIENTS

If you are uninsured or carry Medicaid insurance, our billing office will be happy to assist you with establishing a payment plan.

BILLING PROCESS

Patient statements are sent out every 30 days on or about the 15th of the month. If you are insured, your initial statement will be sent out upon receipt of a remittance notice and/or payment from your insurance carrier (typically 30-45 days from date of service).

PAYMENT FOR SERVICES PERFORMED

Unless a signed "Payment Plan and Agreement" has been established with our billing department, full payment is due within 30 days of the initial statement date. Any amount paid that is less than the full balance due will be considered partial payment whether or not it has been indicated as such on your statement.

Name on Card: _____ Circle Card Type: MC Visa Discover

Card Number: _____ Expiration: ___/____

Please note:

- All balances not paid within 30 days of the date of the initial patient statement may be charged interest of 1.39% per month and any courtesy discount extended may be forfeited.
- Checks returned by your bank are subject to a $25 processing fee.
- The undersigned irrevocably agrees that any unpaid balance remaining due after 90 days may be charged to the credit/debit card provided above.
- All accounts with balances 90 days past due, may be sent to a collection agency and eventually reported to the IRS as taxable income to you. Additionally, you shall be financially responsible for all collection costs and legal fees incurred in the collection of the unpaid balance.
- We will use any means you have provided and/or are available via public record, including but not limited to phone numbers, email addresses and networking sites for the purpose of contacting you regarding your account.

OTHER BILLS

Charges from our office are separate from those you may receive from the hospital, anesthesiologist, and/or other providers.

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I have read and fully understand the financial policy set forth above and i agree to its terms and conditions.

_____ _____ _____

Patient or Legal Guardian Signature | Print Patient Name or Legal Guardian | Date

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ASSIGNMENT OF BENEFITS (FOR INSURED PATIENTS ONLY)

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original..

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient or Legal Guardian Signature	Print Patient Name or Legal Guardian	Date

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NOTICE OF PRIVACY PRACTICES

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 is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "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 condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Your Protected Health Information may be subject to electronic disclosure. We will obtain an authorization from you to authorize any electronic disclosure other than for treatment, payment or healthcare operations purposes.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

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

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school 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 use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information 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 restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You 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 have the right to request an amendment to your protected health information – 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 disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the 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 Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

HIPAA Compliance Officer: Adrienne Raphael 214-934-2506 officemanager@drbransky.com

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.