GRANTS PASS
SURGICAL
ASSOCIATES P.C.

Mark F. Deatherage, MD, FACS
Mark A. Jones, MD

ACKNOWLEDGMENT AND CONSENT

I understand that Grants Pass Surgical Associates, P.C. will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written, electronic or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health related information.

I understand and agree that Grants Pass Surgical Associates, P.C. may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, as well as submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for, quality cost effective health care.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Grants Pass Surgical Associates, P.C. is not required by law to agree to such requests.

I also understand that I have the right to receive and review a written description of how Grants Pass Surgical Associates will handle health information about me. This written description, known as a Notice of Privacy Practices, describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of Grants Pass Surgical Associates, P.C., and my rights regarding my health information.

I further understand that it is the policy of Grants Pass Surgical Associates to follow all federal and state laws and reporting requirements regarding identity theft. Specifically, this policy outlines how Grants Pass Surgical Associates, P.C. will (1) identify, (2) detect, and (3) respond to "red flags" which are defined by this policy as including a pattern, practice, or specific account or record activity that indicates possible identity theft.

I understand that the Notice of Privacy Practices is available to me upon request and that it is the policy of Grants Pass Surgical Associates, P.C. to review and update these policies no less than annually, of which I may have a copy of the updates upon request.

By signing below, I agree that I have reviewed and understand the information above and that I can obtain a copy of the Notice of Privacy Practices upon request.

Print Patient's Name ______________________________

Patient's Signature ______________________________ Date ______________