

*******IMPORTANT INFORMATION PLEASE READ*******

IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY US OF ANY INSURANCE REQUIREMENTS: PRE-CERT, SECOND OPINION, REFERRAL NUMBERS, CO-PAYS, X-RAYS, LAB PREFERENCE OR HOSPITAL PREFERENCE PER YOUR INSURANCE CARRIER.

DENIAL OF CLAIMS OR UNPAID BILLS DUE TO INCORRECT INFORMATION WILL BE THE PATIENTS RESPONSIBILITY.

**Central Surgical Associates, PLLC CANNOT AND WILL NOT CHANGE PHYSICIANS DIAGNOSIS JUST TO COVER NON-COVERED SERVICES OR CLAIMS.
"PLEASE DO NOT ASK"**

PATIENTS ARE RESPONSIBLE FOR ANY CO-PAYMENTS UN-MET DEDUCTABLES AND ANY UN-PAID PORTION OF THE BILL.

I UNDERSTAND THAT ANY ADDITIONAL CLAIM FORMS SUCH AS ATTENDING PHYSICIAN STATEMENTS OR DISABILITY FORMS THAT Central Surgical Associates, PLLC FILLS OUT FOR ME, WILL ONLY BE FILLED OUT ON FRIDAYS AND I WILL BE CHARGED \$ 10.00 PER FORM DUE WHEN FORMS ARE PICKED UP, MAILED OR FAXED. (FMLA FORMS ARE FILLED OUT AT A NO CHARGE)

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS:

I AUTHORIZE Central Surgical Associates, PLLC, NURSE OR TREATING PHYSICIAN TO TREAT ME. I FURTHER AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE COMPLETION OF INSURANCE FORMS. I AUTHORIZE PAYMENT DIRECTLY TO Central Surgical Associates, PLLC AND THE TREATING PHYSICIAN FOR ALL MEDICAL BENEFITS OTHERWISE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE.

I UNDERSTAND THAT WHILE I AM UNDER Central Surgical Associates, PLLC/PHYSICIAN TREATMENT IT IS ALSO MY RESPONSIBILITY TO NOTIFY Central Surgical Associates, PLLC OF ANY CHANGES.

SUCH AS ADDRESS CHANGE, PHONE NUMBER, INSURANCE, JOB, OR MARITAL STATUS. IT IS ALSO MY RESPONSIBILITY TO MAKE SURE Central Surgical Associates, PLLC HAS A CORRECT COPY OF MY INSURANCE CARD(S).

Central Surgical Associates, PLLC WILL FILE YOUR INSURANCE CLAIM FOR YOU. HOWEVER, YOU ARE RESPONSIBLE TO MAKE SURE CLAIMS ARE PAID.

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I HAVE READ THE ABOVE AND UNDERSTAND MY RESPONSIBILITIES.

Patient Signature: _____

Date: _____

7. Are you a "Current Smoker"? How many packs per day? _____
 Do you consume alcohol? How much do you consume per day? _____

"Past Surgical History"

8. Have you had any "major" surgeries in the past?

| Surgery Type | Surgeon | Year | Any Complications |
|--------------|---------|------|-------------------|
| | | | |
| | | | |
| | | | |
| | | | |

"Past Medical History"

9. Please check "**ONLY**" conditions that you "**HAD**" in your past but no longer have today.

| | | | |
|--------------------------|---------------------|--------------------------|-----------------|
| <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | Lung Problems | <input type="checkbox"/> | Other Problems |
| <input type="checkbox"/> | Heart Problems | <input type="checkbox"/> | |

"Family Medical History"

10. Has anyone in your "Immediate Family" ever had the following? Please Circle

| | | | | |
|------------------------------------|---------------------|---------------------|---------------------|----------------------|
| Cancer "List type of Cancer" | Mother Type_____ | Father Type_____ | Sister Type_____ | Brother Type_____ |
| Cardiac Disease | Mother | Father | Sister | Brother |
| High Blood Pressure | Mother | Father | Sister | Brother |
| Respiratory Problems | Mother | Father | Sister | Brother |
| Kidney Problems | Mother | Father | Sister | Brother |

PLEASE SIGN THE FOLLOWING:

Patient Signature: _____

(Parent if patient is minor)

Date: _____

**Central Surgical Associates, PLLC
1190 North State Street Suite 502
Jackson, Ms. 39202-2414**

**Kenneth E. Cleveland, MD
James R. Rooks, MD**

**H. Gregory Fiser, MD
Erin R. Cummins, MD**

**Gina E. Heath, MD
Lee M. Nicols, MD**

Dear Patient,

The next form for you to sign is called an arbitration agreement. This form states that if you are unhappy with our services here and want to file a lawsuit you will agree to go in front of an arbitrator instead of a twelve person jury trial. An arbitrator is a retired lawyer or judge. A law firm in another state chooses this person so the person is not partial to either party. Our clinic does require you to sign this before you meet with the physician for an office visit or procedure. If you want to make any changes to this form the physician will review it and will make the decision regarding treatment. If you refuse to sign this form our clinic will be happy to refer you to another physician or back to the physician that referred you to our clinic. Please carefully read the arbitration agreement and if you still have any questions call our office at 601.944.1781. Please sign the highlighted areas and initial the highlighted boxes on the back of the arbitration.

Thank you,

Central Surgical Associates, PLLC

CLINIC – PHYSICIAN – PATIENT ARBITRATION AGREEMENT

_____, ("Patient") engages Central Surgical Associates, PLLC, or employee(s) thereof ("Clinic"), Kenneth Cleveland, M.D., PLLC, J. Russell Rooks, M.D., PLLC, H. Gregory Fiser, M.D., PLLC, Erin R. Cummins, M.D., PLLC, Gina E. Heath, M.D., PLLC, Lee M. Nicols, M.D., PLLC, or member(s) or employee(s) thereof ("Members"), and each Physician that renders medical care and services to perform services in conjunction with Patient's medical care. For and in partial consideration of the rendition of any and all present and future medical care and services, Patient agrees that in the event of any dispute, claim or controversy arising out of or relating to the performance of medical services, including but not limited to, patient fees, informed consent, negligence or medical malpractice, between Patient (whether a minor or an adult) or the heirs-at-law or personal representative(s) of Patient, as the case may be, and the Clinic, the Members, and each Physician individually, where the claim or the amount in controversy exceeds \$5,000, such dispute or controversy shall be submitted to JAMS, or its successor, on an arbitration form for final and binding arbitration. All claims for unliquidated damages shall be deemed claims for in excess of \$5,000.

Either party may initiate arbitration of any matter subject to arbitration by filing a written demand for arbitration at any time. Patient shall be entitled to an in-person hearing in his or her county in accordance with the Federal Arbitration Act. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures and Minimum Standards of Procedural Fairness, and all parties agree to be bound by the arbitrator's decision. Any decision by the arbitrator(s) shall be accompanied by a reasoned opinion. Judgment may be entered on the arbitrator's award, if any, by the court having jurisdiction of the subject matter.

All parties agree that their relationship affects interstate commerce and that this Agreement shall be governed by the Federal Arbitration Act and, if not, by Mississippi law. The party requesting arbitration shall bear all costs of the arbitration, except the Patient is not required to pay any more than \$125.00, with Clinic or Members bearing the other arbitration costs.

If you are not willing to submit to binding arbitration, the Clinic may perform the services or refer you to another health care provider capable of rendering the medical care or services which you require (although Physician assumes no responsibility for the quality of care or service rendered by any other health care provider). **Please inform a Clinic representative immediately if you do not agree to binding arbitration and desire such referral.**

This Agreement may be rescinded by written notice by either party within fifteen (15) days of signature. However, any claim or dispute related to medical services rendered after execution of this Agreement and prior to the date of such written notice of rescission shall be subject to the terms of this Agreement. Written notice of such rescission may be given by a guardian or conservator of Patient if Patient is a minor or incapacitated. If any portion of this Agreement is found unenforceable, that portion shall be stricken and the remainder of this Agreement fully enforced. If a court rules that the dispute must be litigated and not arbitrated, Patient agrees the suit will be heard in the county where services are rendered.

NOTICE: BY SIGNING THIS AGREEMENT YOU ARE AGREEING TO HAVE ANY CLAIM OF NEGLIGENCE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR STATUTORY AND CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL.

Witness our signatures this the ____ day of _____, 200____.

**CENTRAL SURGICAL ASSOCIATES, PLLC
KENNETH CLEVELAND, M.D., PLLC
J. RUSSELL ROOKS, M.D., PLLC
H. GREGORY FISER, M.D., PLLC
ERIN R. CUMMINS, M.D., PLLC
GINA E HEATH, M.D., PLLC
LEE M. NICOLS, M.D., PLLC
and associated Physicians**

PATIENT

By: _____
Authorized Representative

By: _____
Patient

If a parent or guardian has signed on behalf of their minor child or ward, such parent or guardian hereby attests that he or she has full legal authority to execute this agreement on behalf of said child or ward. Furthermore, said parent or guardian hereby agrees to indemnify and hold harmless the Clinic, the Members, and their employees and Physicians from any claim, demand or loss which may occur in the event said parent or guardian does not, in fact, have such legal authority.

By: _____
Parent or Guardian

A photostatic or electronic copy of this authorization shall be considered as effective and as valid as the original.

Physician Initials

SUMMARY OF ARBITRATION AGREEMENT

Medical staff must carefully explain the Agreement to each Patient. Have the Patient initial beside each of the following points after you explain them.

| | Explain: | Patient's Initials |
|-----|--|--------------------|
| 1. | Before signing the Agreement the Patient may make written changes in the Agreement if they so desire and present these to the Clinic for approval. | _____ |
| 2. | The Patient is agreeing to arbitrate any disputes above \$5,000. You are agreeing not to sue the Clinic, its Members, or any of their Physicians or employees in a court of law. | _____ |
| 3. | The Patient is waiving his or her constitutional or statutory right to a jury trial. | _____ |
| 4. | Arbitration will be performed by JAMS. This is a national association of neutral arbitrators. They don't work for the Clinic, Physician(s), or for the Patient. The Clinic or the Members will pay the costs, except for the first \$125.00, and each side will pay for their own attorneys and other costs. | _____ |
| 5. | This Agreement is effective to the date of this Agreement. | _____ |
| 6. | The Patient can rescind this Agreement within 15 days, but must still arbitrate any claim arising before the Agreement is rescinded. | _____ |
| 7. | If the Patient does not agree to arbitrate, or if you rescind this Agreement, the Clinic will either treat the patient or immediately refer them to another doctor or group who can provide the medical care they need. The Patient is not in need of emergency care or under immediate stress. | _____ |
| 8. | If a court rules that a dispute must be litigated and not arbitrated, any lawsuit must be filed in the county where services are rendered. | _____ |
| 9. | In arbitration each side will have a fair opportunity to present their evidence, but court rules do not necessarily apply. There is no appeal except in limited circumstances. | _____ |
| 10. | Patient, Physician(s), Members and the Clinic all have the right to terminate their relationship at anytime. | _____ |
| 11. | A claim by you or the Physician(s), Members, or Clinic will be waived and forever barred if, on the date of the demand for arbitration, the claim would be barred by the applicable statute of limitations. | _____ |
| 12. | If you still have any questions, you should consult an attorney before signing. | _____ |
| 13. | The Patient has read the attached Questions and Answers and understands them. | _____ |

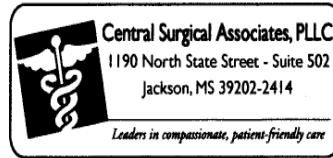
I hereby confirm that I have explained the Agreement to the Patient, and the Patient has affirmed his or her understanding of the Agreement by initialing or signing beside each of the foregoing provisions.

CENTRAL SURGICAL ASSOCIATES, PLLC,
 KENNETH CLEVELAND, M.D., PLLC, J.
 RUSSELL ROOKS, M.D., PLLC, H. GREGORY
 FISER, M.D., PLLC and ERIN R. CUMMINS,
 M.D., PLLC, GINA E. HEATH, M.D., PLLC, LEE
 M. NICOLS, M.D., PLLC, and associated
 Physicians

By: _____
 Authorized Representative

 Physician Initials

HIPAA 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 describes how we 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 or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

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.

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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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 activities, employee review activities, training of medical students, licensing, 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.

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, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' 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 required 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 an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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 protected health information that is subject to law that prohibits access to protected health information.

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 a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information 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 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 may have the right to have your physician amend 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 we have made, if any, of your protected health information.

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 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 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 practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

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

Print Name: _____ Signature _____ Date _____