SURGCENTER HUDSON, LLC

5700 DARROW ROAD, SUITE 109 • HUDSON OH 44236

Phone: (330) 655-5460 Fax: (330) 655-5461

Patient's Rights and Notification of Physician Ownership

Rights and Respect for Property and Person

The patient has a right to:

- Exercise his/her rights without being subjected to discrimination or reprisal.
- Voice grievance regarding treatment or procedure or care that is, or fails to be, furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Confidentiality of personal medical information.

Privacy and Safety

The patient has the right to:

- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.

Advance Directives:

You have the right to information on the center's policy regarding Advance Directives.

Advance Directives will not be honored within the center. In the event of a life-threatening event, emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family. If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes. If you request, an official state Advance Directives Form will be provided to you.

Submission and Investigation of Grievances:

You have the right to have your verbal or written grievances submitted, investigated and to receive a written notice of the Center's decision.

The following are the names and/or agencies you may contact:

Erica Shaffer
330-655-5460
5700 Darrow Rd., Ste. 109
Hudson, OH 44236

OHIO DEPARTMENT OF HEALTH
1-800-669-3534
246 North High Street
Columbus, OH 43215
State Web Site: www.odh.ohio.gov

Sites for addresses and phone numbers of regulatory agencies:

MEDICARE Ombudsman Website
www.medicare.gov/Ombudsman/resources.asp

MEDICARE
www.medicare.gov
1-800-MEDICARE (1-800-633-4227)

Office of Inspector General
https://oig.hhs.gov

Physician Financial Interest and Ownership:

The center is owned, in part, by the physicians. The physician(s) who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations.

By signing below, you, or your legal representative acknowledge that you received, read and understand this information (verbally and in writing) in advance of the date of the procedure and have decided to have your procedure performed at this center.

_____

Signature of Patient or Legal Representative

_____

Date

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF YOUR PROCEDURE.

SURGCENTER HUDSON, LLC

AS A PATIENT OF SURGCENTER HUDSON YOU HAVE THE RIGHT TO RECEIVE THE FOLLOWING INFORMATION IF YOU NEED, IN ADVANCE OF THE DATE OF YOUR PROCEDURE.

PATIENT'S BILL OF RIGHTS: EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL WITH HIS/HER RIGHTS RESPECTED. THE FACILTY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING LIST OF PATIENT RIGHTS:

- To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
- To be treated with respect, consideration and dignity in receiving care, treatment, procedures, surgery and/or services.
- To be provided privacy and security of self and belongings during the delivery of patient care service.
- To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.
- To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.
- When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.
- To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.
- To be free from mental and physical abuse, free from exploitation, and free from use of restraints. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.
- Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.
- To leave the facility even against the advice of his/her physician.
- Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.
- Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the facility.
- To know the identity and professional status of individuals providing services to them and to know the name of the physician who is primarily responsible for coordination of his/her care.
- To know which facility rules and policies apply to his/her conduct while a patient.
- To have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's rights.
- To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's usual care. The patient's written consent for participation in research shall be obtained and retained in his/her patient record.
- To examine and receive an explanation of his/her bill regardless of the source of payment.
- To appropriate assessment and management of pain.
- **IF YOU NEED A TRANSLATOR:** If you need a translator, please let us know and one will be provided. If you have someone who can translate confidential, medical and financial information, please make arrangements to have them accompany you on the day of your procedure.

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Financial Policy and Disclosure:

If you have insurance, we will help you receive maximum benefits by filing a claim for you as a courtesy, provided we have your assignment of benefits. You realize that your insurance coverage is a contract between you and the insurance company. Please be sure to check with your insurance company for need for pre-authorization or referrals. Keep in mind that not all services are a covered benefit.

Please note there are separate service components for which you will be billed separately:

A. **Professional Fee –** This is the charge for your physician to perform your procedure and will be billed from the Physician's office.

B. **Procedure Room Fee –** This is the charge for use of the center, including, medications, nursing care, and equipment. This will be billed from SurgCenter Hudson.

C. **Anesthesia Fee –** This charge is for anesthesia administration and monitoring during your procedure and will be billed from the anesthesia company.

D. **Laboratory and Pathology Fee –** If you have any cultures or specimens taken such as a biopsy or lesion removal, you will receive a bill from the pathology lab's office that performed the tests.

We understand multiple bills can be confusing. Please do not hesitate to contact us for any further questions regarding your bill.

A staff member and/or physician has informed me that the physician rendering services, may have ownership interest in SurgCenter Hudson. I have been given the option to be treated at another facility, which I have declined.

Authorization for treatment, Assignment of Benefits and Information Release:

I hereby request and consent to treatment and services reasonable and proper by today's standards provided by SurgCenter and authorize payment directly to the physician of medical benefits, if any, otherwise payable to me by Medicare or other insurance companies for his/her services except as limited by law. I also hereby authorize SurgCenter to release any information to the Healthcare Financing Agency or it's agent to third party payers and anyone assisting the provider in obtaining payment including billing, coding and collection agents, provider's attorney, consultants and to my insurance company as required in the course of my examination or treatment. This agreement is valid for the duration of the claims and appeals process, but not to exceed two years.

I have read and agree to the Terms of Service:

Patient Signature:_____

Date:_____

Witness:_____

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RELEASE OF PRIVATE HEALTH INFORMATION

Patient Name:_____ Date:_____

Date of Birth:_____

Please list family or friends that you would like us to be able to share information with:

_____

Please initial what information you give permission to share:

_____ Financial Billing

_____ Health Information, including results or treatment for services provided.

Authorization is valid until: (Initial one)

_____ As long as I am a patient here

OR

_____ Until date of:_____

Do you have an Advance Directive or Living Will?

❑ Yes ❑ No

Would you like information about Advance Directives?

❑ Yes ❑ No

Patient Signature:_____ Date:_____

Witness:_____