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Weston Outpatient
Surgical Center

- Please be advised when it comes to surgery, you are Responsible for your deductible, co-insurance and co-pays estimated in advance.

- There are three main financial responsibilities for your surgery or procedure:

    1. Weston Outpatient Surgical Center
    2. Anesthesia services (based on length of your procedure (separate bill from Weston Outpatient Surgical Center)
    3. Your physician (billed through his or her office, separate bill from Weston Outpatient Surgical Center)

- If you have Blue Cross Blue Shield, Vista/Coventry or Aetna insurance, you might be receiving an additional bill from (Implantable Provider Group) depending on your benefits for any implants (plates, screws, tissue grafts, etc.) used at the time of surgery.

Thank you!

WESTON
Outpatient Surgical Center

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PATIENT RIGHTS

The patient has the right to:

- Be informed of his/her rights in advance of receiving care. The patient may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex, culture, economic, education, religious background, physical handicap, or the source of payment for care.
- Considerate, respectful and dignified care, provided in a safe environment, with protection of privacy, free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- The name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see them. The patient has a right to request a change in providers if other qualified providers are available.
- Be advised if the physician has a financial interest in the surgery center.
- Be advised as to the absence of malpractice coverage, if applicable.
- Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes), and prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment. Be informed of the facility's policy and state regulations regarding
- advance directives and be provided advance directive forms if requested.
  Receive a copy of a clear and understandable itemized bill and receive and explanation of his/her bill
- regardless of source of payment.
  Receive upon request, full information and necessary counseling on the availability of known
- financial resource for his/her care, including information regarding facilities discount and charity policies.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his/her health care.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility. His/her written permission will be obtained before medical records can be made available to anyone not directly concerned with their care.

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- Receive information in a manner that he/she understands. Communication with the patient will be effective and provided in a manner that facilitates understanding by the patient regardless of age or impairment.
- Access information contained in his/her medical record within a reasonable time frame.
- Be advised of the facility's grievance process, should he/she wish to communicate a concern regarding the quality of the care they received. Notification of the grievance process includes: whom to contact to file a grievance, and that he/she will be provided with a written notice of the grievance determination that concerns the name of the facility's contact person, the steps taken on his/her behalf to investigate the grievance, the results of the grievance, and grievance completion date.
- Be advised of contact information for the state agency to which complaints can be reported, as well as contact information for the office of the Medicare Beneficiary Ombudsman.
- Be advised if the facility/personal physician proposes to engage in or perform human experimentation affecting their care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's rights to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided it subjects will be contained in the medial record or research file, along with the consent form(s).
- Be informed by his/her physician, or a delegate of thereof, of the continuing healthcare requirement following their discharge from the facility.
- Be informed if Medicare eligible, upon request and in advance of treatment, whether the health care provider or healthcare facility accepts the Medicare assignment rate.
- Receive upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the healthcare facility or provider's office to accompany the patient while the patient is receiving treatment or is consulting with his or her health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or cannot be reasonably accommodated by the facility or provider,

PATIENT RESPONSIBILITIES

- The patient or guardian is responsible for:
- Providing accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over the counter products and dietary supplements), allergies and sensitivities and other matters relating to his/her health.
- Keeping appointments and for notifying the facility or physician when he/she is unable to do so.
- Asking questions when the patient or responsible adult does not understand what they have been told about the patient's care or what they are expected to do.
- Following the treatment plan established by his/her professionals as they carry out the physician's orders.
- Reporting to the health care provider any unexpected changes in his/her condition.
- Providing a responsible adult to transport him/her home from the facility and remain with him/her for 24 hrs. unless exempted from that requirement by the attending physician.
- Having a parent or guardian remain in the facility for the duration of the patient's stay in the case of pediatric patients.
- His/her actions should treatment be refused or not followed per your physician's orders.
- Assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
- Following facility policies and procedures.
- Informing the facility about advance directives.
- Being considerate of the rights of other patients and facility personnel.
- ·espectful of his/her personal property and that of other persons

WESTON Outpatient Surgical Center

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ADVANCE DIRECTIVE NOTIFICATION

You have the right to information regarding advance directives, this facility's policy on advance directives, and information regarding state regulations concerning advance directives. Applicable state forms are available from the center and will be provided upon request.

When a person becomes unable to make decisions due to a physical or mental change or condition, they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death. The state rules that address this include 58-A2.0232. 59A-3.254, 59A-4.106, 59A-8.0245, and 59A=12.013, Florida Administrative Code and Florida statute Title XLIV, Chapter 765.

Weston Outpatient Surgical Center respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.

If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

If you wish to complete an Advance Directive, copies of the official forms are available at:

http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/index.shtml

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

If a patient is adjudged incompetent under the state's laws, the rights of the patient are exercised by the person appointed and/or legal representative designated by the patient under Florida law to act on the patient's behalf. The center will accept a Court Appointed Guardian, Dual Power of Attorney, or a Health Care Surrogate.

PATIENT COMPLAINT OR GRIEVANCE

If you have a problem or complaint, please speak to the receptionist or your caregiver who will address your concern(s) promptly.
If necessary, your problem or complaint will be advanced to the Administrator and/or Quality Assurance Coordinator for resolution. You will receive a letter or phone call to inform you of the actions taken to address your complaint.
If you are not satisfied with the response of the Surgery Center, you may contact:

Patient complaints or grievances may be filed through the state of Florida Consumer Services Unit at 1-888-419-3456 (press 2) or write to the address below:
Agency for Health Care Administration, Consumer Assistance Unit, 2727 Mahan Drive/BLDG. 1 Tallahassee, Florida 32308
You can also access the new online Medicaid complaint form webpage: **http://ahca.myflorida.com/Medicaid/complaints/**

If you have a complaint against a health care professional and want to receive a complaint form, call Consumer Services Unit at 1-888-419-3456 (press 2) or write to the address below:

Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399

You may contact AAAHC by mail at:

Accreditation Association for:
Ambulatory Health Care, INC.
5250 Old Orchard Road, Suite 200
Skokie, Illinois 60077

You may also contact the Facility Administrator:
Randy Huffman, Administrator
Weston Outpatient Surgical Center
2229 North Commerce Parkway, Weston, FL 33326

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman.
Visit the Ombudsman's webpage on the web at:
www.cms.hhs.gov/center/ombudsman.asp
www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

DISCLOSURE OF OWNERSHIP

The following physicians have financial interest in this facility: J. R. Baylis, MD; M.Berkowitz, MD; A. Bertot, MD; D. Blum, MD; R. Cardoso MD; M. Cohen, DPM; L. Davis, DO; A. DeSimone, MD; Feanny, MD; M. Fishman, DO; M. Gedallovich, MD; H. Gellman, MD; N. Gomez, MD; A. Gousse, MD; S. Greenberg, MD; G. Hindin, MD; F. Jones, DO; T. Kinchelow, MD; K. Kosche, MD; C. Messina, DPM; F. Moya, MD; B. Schapiro, MD; J. Shaw, DO; D. Sheikh, MD; R Sheinberg, DPM; W. Windram, DPM

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FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. The account may be sold to a third party for the collection of outstanding balances. If for any reason, the bill is not paid within a period (60) days, the patient will be responsible for the full payment and any applicable collection expenses or legal fees.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Weston Outpatient Surgical Center, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at Weston Outpatient Surgical Center may have an ownership interest in Weston Outpatient Surgical Center. I have received a complete list of physician owners of Weston Outpatient Surgical Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Weston Outpatient Surgical Center

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

I hereby acknowledge that a copy of the Notice of Privacy Practices for Weston Outpatient Surgical Center has been made available to me. I have the right to obtain a paper copy upon request.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding Weston Outpatient Surgical Center policies pertaining to ADVANCED DIRECTIVES and the grievance procedure.

PROCEDURE AND BILLING COMMUNICATION AUTHORIZATION

I hereby authorize the Weston Outpatient Surgical Center and/or the physician performing my procedure today to communicate information regarding my procedure/results of my procedure/billing to/with:

- My spouse/family member/other Name(s): _____ _____Initials

The undersigned certifies that he/she has read and understands the foregoing and full accepts all terms specified above.

_____ _____

Signature of Patient or Responsible Party Date Signed

_____

Relationship to Patient

_____ _____

Witness Signature Date Signed

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Outpatient Surgical Center

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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.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures
Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures
We may be required or permitted to use or disclose the information even without your permission as described below:
Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.
Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.
Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.
□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.
□ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
□ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.
□ You have the right to request that we amend your information.
□ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Randy Huffman, Center Leader

I,_____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____Date:_____

If not signed, reason why acknowledgement was not obtained:_____

Staff Witness seeking acknowledgement
_____Date:_____

Effective Date: March 26th, 2013