ASI SURGERY CENTER, INC.
PATIENT ACKNOWLEDGEMENT

*** Disclosure of Ownership: Your Physician <u>may</u>** have a financial interest in this facility.

PATIENT'S RIGHTS:

- Patients are treated with respect, consideration, dignity and provided appropriate personal privacy.
- Patients have the right to receive adequate notice regarding this facility's privacy practices. Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse the release, except when release is required by law.
- Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis. 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.
- Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- Patients have the right to the facility's rules and regulations as they apply to their conduct, responsibilities and participation as a patient.
- The patient has the right to change their provider if other qualified providers are available.
- Be fully informed of the scope of services available at the facility, provisions for after-hours and emergency care, and related fees for services rendered.
- Be informed of charges, fees for service, payment policies, receive an explanation of your bill and
- receive counseling on the availability of known financial resources for health care services.
- Be informed of your right to refuse to participate in experimental research if applicable.
- Know that this facility does not honor advance directives; however, any advance directive will be noted in the patient medical record and will be communicated to other medical facilities, if a transfer is needed.
- The patient has the right to receive enough information from the physician so that he/she can understand the services being rendered in order to sign the informed consent.
- The patient may leave this facility, even against the advice of his or her physicians.
- Reasonable continuity of care and advance knowledge of the time and location of appointment, as well as knowledge of the physician providing the care.
- Be free from all forms of abuse, discrimination, harassment or reprisal. Receives access to equal medical treatment and accommodations regardless of race, creed, sex, national origin, religion, or sources of payment for care.
- Know that your physician may have financial interests or ownership in this facility.
- Know the name and role of your caregiver (e.g., doctor, nurse, technician, etc.). You have a right to
- request information, malpractice insurance coverage and/or credentials about the physician providing your care.
- Report any comments or voice any grievances concerning the quality of services provided to the patient during the time spent at the facility without being subjected to discrimination or reprisal and receive timely, fair follow-up on your comments.
- Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.

PATIENT'S RESPONSIBILITIES:

- Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- Follow the treatment plan prescribed by his/her provider.
- Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours. If required by his/her provider.
- Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Be respectful of all the health care providers and staff, as well as other patients.
- Respect the privacy of other patients.
- To work with your health care team and to follow all safety rules.
- To tell your doctor about any changes in your health after you leave our facility.
- To keep, or cancel in a timely manner, your scheduled appointments for your health care.
- To tell your health care team if you wish to change any of your decisions.
- To ask for clarification if you do not understand any information or instructions given to you by your health care team.
    - **IF YOU HAVE CONCERNS:**
    - If you have any questions or concerns about your responsibilities, you can contact our administrator or if you wish to file a complaint about your care in our facility please refer to your Patient Rights for addresses and telephone numbers.

ADVANCE DIRECTIVE:

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. FACILITY NAME respects and upholds those rights.

However, unlike in an acute care hospital setting, FACILITY NAME does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this facility, we, the personnel at this facility, will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or healthcare Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you would like additional information in regards to Advance Directives, we will be happy to supply you with this information. If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure

PATIENT COMPLAINT OR GRIEVANCE

- If you have a problem or complaint, please speak to the receptionist or your caregiver. We 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:

State Department of Health Services- Los Angeles County
5555 Ferguson Drive, Suite 320, Commerce, CA 90022
(323) 890-8500

- All Medicare beneficiaries may file a complaint or grievance with the Medicare Beneficiary Ombudsman. You may call:
  1-800-MEDICARE and they will direct your inquiry to the Medicare Ombudsman. You may write to them at:

Center for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

You may visit the Ombudsman's webpage on the web at: www.cms.hhs.gov/center/ombudsman

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how this facility 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.

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 obtain payment for your health care bills, to support the operation of the physician's practice, and any other use require 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 physical therapist or rehabilitation therapist 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.

Your physician is not required to agree to a restriction that you may request. If your 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.

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

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 were 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 may include, but are not limited to: as Require 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 require 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 and 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 necessarily have access to 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 this facility 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 of 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.

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 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 have the right to file a complaint directly to the Office of Civil Rights
Complaints should be made in writing to this facility and/or the entities listed below if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer or Administrator. **We will not retaliate against you for filing a complaint.**

- **U.S. Dept. of Health & Human Services, 200 Independence Ave, Washington, D.C. 20201 (877) 696-6775**
- **State Department of Health Services- Los Angeles County 5555 Ferguson Drive, Suite 320, Commerce, CA 90022 (323) 890-8500**
- **AAAHC, 5250 Old Orchard Road, Suite 200, Skokie, IL 60077 (847) 853-6060**

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 office manager, in person or by phone at our Main Phone Number.

ASI SURGERY CENTER, INC.
ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of the Privacy Notice/HIPAA Policy. I have had the opportunity to review the Notice od Privacy Practices prior to signing this acknowledgement. I Understand that if I would like a copy of these policies, I will be supplied one by ASI Surgery Center, Inc. ASI Surgery Center, Inc., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy practices may be obtained by forwarding a written request to Ilya Reyter, MD at 4836 Van Nuys Blvd., Sherman Oaks, CA 91403.

I acknowledge that prior to my surgery date, I have received verbally and in writing, the following information:

- Patient Rights and Responsibilities
- Disclosure of Ownership
- Grievance Policy
- Advance Directives Policy

I am also aware that if I have further questions or need assistance with obtaining more information regarding these issues, I may call ASI Surgery Center 818-907-7546.

_____
Print Name Patient/Patient Representative

_____
Signature Patient/Patient Representative

_____
Date

Do you have an ADVANCE DIRECTIVE?

_____ Yes, If you answered yes, please be aware that this facility does not honor Advanced Directives.
I understand that this facility does not honor Advanced Directived.

Sign:_____ Date: _____

_____ No, If no would you like more information about Advanced Directives?
_____ NO
_____ YES: A copy of Advanced Directive was provided Initials:_____

Witness:_____Date:_____