Hamilton Eye Institute Surgery Center LP

"Your Right to Know"

The healthcare facility must inform the patient or the patient's representative or surrogate of the patient's rights and must protect and promote the exercise of these rights, as set forth in this document. If a patient is adjudged incompetent under applicable State laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf. If a State court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.

GRIEVANCES

An opportunity for you, your family, or a legally appointed representative to express any concerns about your care, with the assurance that any expressed concerns will not interfere with present or future care. The Surgery Center Administrator will assist you with the review and when possible, the resolution of these concerns:

Solus Management Services - 901-516-1716

Hamilton Eye Institute Surgery Center – 901-448-3900

Tennessee Health Department - 615-741-3111

Medicare – www.medicare.gov - 800-633-4227

www.cms.hhs.gov/ombudsman

Accreditation Association of Ambulatory Health Care Inc - 847-853-6060

Patient Rights

- To be treated with respect, consideration, and dignity.
- To be free from any act of abuse, discrimination, harassmentor reprisal.
- To expect reasonable continuity of care.
- To personal privacy.
- To receive care in a safe setting.
- To expect that within the healthcare facility's capacity efforts will be made to honor a patient's request for services.
- To receive complete current information concerning diagnosis, treatment, and prognosis, in terms the patient can reasonably expect to understand from their physician. When it is not medically advisable to give that information to the patient, it should be made available to the appropriate person on their behalf.
- To the name of the physician responsible for coordinating their care.
- To receive all information necessary to give informed consent prior to the start of any procedure and/or treatment from their physician.
- To be given the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons.
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences.
- To be informed of any relationship of the healthcare organization to other pertinent healthcare and education institutions.
- To know what rules and regulations apply to their conduct as a patient.
- To voice concerns or grievances regarding treatment or care furnished within this facility.
- To receive information concerning policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms.
- To be advised if the healthcare facility proposes to engage in or perform human experimental care or treatment, and have the opportunity to accept or decline.
- To the credentials of health care professionals.
- To the disclosures and records that are kept confidential, and to be given the opportunity to approve or refuse their release except when release is authorized by law.
- To expect communication, records, discussion, consultation, examination and treatment to be treated confidentially.
- To examine and receive an explanation of their bill regardless method of payment.
- To change providers if other qualified providers are available

Patient Responsibilities

- Pre-operatively all mentally competent patients 18 years or older (or an emancipated minor) will be asked before their procedure if he/she has an Advanced Directive.
- It is the patient's responsibility to provide a copy of his/her Advance Directive for the Surgery Center and the admitting physician.
- The Advanced Directive will be provided to the receiving hospital, if the patient is transferred to the hospital.
- Patients not having an Advanced Directive will be given the information upon their request. The information is available in the Patient Information Book, kept in the surgery center lobby.
- Should the patient be designated a Do Not Resuscitate (DNR), the patient will be directed to discuss with his/her Surgeon the appropriateness of implementation of a DNR in the Surgery Center setting.
- If the patient insists on implementing a DNR while at the Surgery Center, the procedure will be canceled and re-scheduled in a hospital setting.
- The Surgery Center will make available the State of Tennessee approved forms for use, should an Advanced Directive be desired.

Do you have an Advanced Directive? ☐Yes ☐No
If yes, did you bring them with you? ☐Yes ☐No ☐N/A

I have received verbal and written communication of "Right to Know" prior to the start of the surgical procedure.

Patient / Surrogate Signature Date

NOTIFICATION OF PRIVACY PRACTICES AND FINANCIAL POLICY

Complete and sign the following

This shall serve as notice that a copy of our "Notice of Privacy Practices" and a copy of our Financial Policy are on display in the waiting room. You may request a copy of these documents from the front desk personnel.

Patient/Guardian Signature Date

I agree to have the Surgery Center staff acknowledge my presence here at the Center and my general condition to family and friends who inquire about me either in person or by telephone.

☐ I agree ☐ I disagree

I acknowledge that a responsible adult must remain at the Surgery Center until I am discharged.

☐ I agree

I give permission to allow the Surgery Center to give or receive information regarding my post-operative care to the following people:

Phone	Person/Relationship	May Leave a Message
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

NOTE: If there is anyone that you wish for us to withhold information, please list below:

☐ **I have no one that you will need to refrain from withholding my information.**

Person	Person

Patient/Guardian Signature Date

Medicare Secondary Payor Questionnaire

(Patient Label)

NOTE: Medicare law requires we determine if another insurer might cover your medical services. In order to assist us in the correct billing of these services, please answer the following questions.

1. Is your injury/illness due to a work related accident/condition? Yes ☐ No ☐
2. Is your injury/illness due to an automobile accident? Yes ☐ No ☐
3. Is your injury/illness due to an accident other than an automobile accident? Yes ☐ No ☐
4. Is your injury/illness due to the fault of another party? Yes ☐ No ☐
   (If you answered yes any question in 1-4 please complete)

   Name of insurer: _____ Policy#: _____

   Address: _____

   Accident Date: _____ Location: _____
5. Are you receiving benefits under the Black Lung Benefits Act (BL)? Yes ☐ No ☐
6. Are you eligible for coverage under the Veteran's Administration? Yes ☐ No ☐
7. Do you have ESRD (End Stage Renal Disease)? Yes ☐ No ☐ (If yes, complete A-D)
   A. Have you received a kidney transplant? Yes ☐ No ☐
   B. Have you received maintenance dialysis treatments? Yes ☐ No ☐ Date dialysis began: _____
   C. Are you within the 30-month coordination period? Yes ☐ No ☐
   D. Were you receiving group health plan (GHP) coverage prior to or on the date of Medicare entitlement due to ESRD? Yes ☐ No ☐

      Name and address of the employer through which you received the GHP:

      _____

      Name and address of GHP: _____

      Policy number (may be called health insurance benefit package number):_____

      Group number: _____ Name of policyholder: _____

      Relationship to patient (if other than self) _____
8. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member? Yes ☐ No ☐ (If yes, complete E-F)

   E. How many employees, including you or your spouse, work for the employer from whom you have GHP coverage? ☐ 1-19 ☐ 20-99 ☐ 100 or more
   F. Name and address of the employer through which there is GHP:

      _____

      Policy number (may be called health insurance benefit package number):_____

      Group #: _____ Date GHP coverage began: _____

      Name of policy holder: _____ Relationship: _____

Thank you for your cooperation in ensuring that your medical services will be billed correctly.

Your Signature_____ **Date** _____

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, ASSIGNMENT OF INSURANCE, BENEFITS, AND FINANCIAL AGREEMENT

This Surgery Center shall be referred to as the provider in this document.

A. MEDICAL AND SURGICAL CONSENT: The undersigned consents to any examination (x-ray or otherwise), including but not limited to, laboratory procedures, medications, infusions, transfusions of blood and blood products, anesthesia, surgical procedure or treatment (including the placement of prosthesis within a patient's body), radiation therapy (x-ray, cobalt, radium or other), photograph and/or other services rendered the patient by members of the medical staff, their representatives and/or associates, and provider's employees under the instructions of the physician, podiatrist or dentist. The undersigned also consents to observation or surgical, diagnostic, or other procedures by medical personnel in training or by other appropriate persons permitted by provider or departmental policy. To protect against possible transmission of blood-borne diseases such as Hepatitis-B or Acquired Immune Deficiency Syndrome (AIDS), I understand that it may be necessary to test the patient's blood while in the Surgery Center. If, for example, a Surgery Center employee or physician is stuck by a needle while drawing blood or sustains a scalpel injury, I understand and consent that the patient's blood will be tested. I further understand that the blood will not be routinely tested for these diseases and the results of any testing will be kept confidential in accordance with Tennessee Law.

B. HEALTH CARE PROVIDERS: Medical personnel, including treating physicians, should provide my care or treatments, may not be employees of the provider. These persons include emergency room physicians, pathologists, radiologists, anesthesiologists, anesthetists, psychologists and certain nurses and aides, I agree that it is my responsibility to ask questions sufficient to make informed decisions based on the employment status/affiliations of my health care providers.

C. TISSUE SPECIMEN ANALYSIS AND DISPOSAL: Should my medical stay involve the removal of any tissue or parts of my body, including fetus or afterbirth, they may be retained or disposed of by the provider or forwarded to appropriate diagnostic entities for review and/or analysis.

D. MEDICAL INFORMATION RECEIVED: The patient, if in a condition to receive it, and if not, the undersigned representative of the patient, acknowledges that he/she has been informed concerning the need for medical services, the purpose of the patient entering the facility, and the planned examinations, procedures, and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained.

E. RELEASE OF INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS: The provider or my physician, may disclose all or any part of the record of the patient to any person or organization which is or may be liable for or responsible for payment of any of the charges of the provider but not limited to insurance companies, medical or hospital service companies, worker's compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or intermediaries or carriers any information needed for this or a related Medicare/TennCare claim. I hereby authorize direct payment to the above-named provider of all health, hospitalization, and all other insurance benefits and assign and transfer all benefits that I am entitled to or otherwise: are due or payable to me or my estate from any source. I have completed and signed the Medicare Secondary Payor Questionnaire.

F. FINANCIAL AGREEMENT: The undersigned SEVERALLY, agree, whether signing as a patient or otherwise, that in consideration of the services rendered to patient, payment of the account is guaranteed by the undersigned in accordance with the regular rates and terms of the provider, as set forth in the providers procedure index, and is payable to the provider. While any insurance or other protection related to the account of the provider may be hereby assigned to and payable directly to the provider, the undersigned clearly understands that the obligation to pay the provider is primarily on the patient and the undersigned, and while insurance received by the provider will be applied to the patient's account, any part of the account not paid by insurance is nevertheless owing and payable. In case of default of payment, and if these accounts should be placed in the hands of a Collector or an Attorney for collection, all collection fees, attorney fees (which shall equal one-third of any balance due), cost and other expenses will be paid by the undersigned. Notice of dishonor, demand and protest are waived. It is further agreed that due to the high cost of billing and refunding small amounts, the surgery center will not bill or refund under payments or overpayments of less than five dollars ($5.00) on final balances, except on a request of the patient or responsible party.

The above conditions apply to all units within the provider system and this form is valid at each provider for the length of the admission including any discharge and readmission to another unit or facility of provider during hospitalization. The release of information set forth hereinabove is valid for one year from the date of discharge, and the assignment of insurance benefits and financial agreement is valid and binding until final settlement of the account is received. Futher, I agree that the terms of this agreement shall apply to all subsequent and future services rendered to me, my spouse, or my dependents by the provider unless this agreement is revoked by written notice sent certified mail prior to the subsequent date of admission.

If you have any comments or concerns about any part of your care, please call 901-516-1716.

THE UNDERSIGNED CERITIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ THE FOREGOING, HAS RECEIVED A COPY HEREOF, IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT, AND THE FOREGOING CONDITIONS OF ADMISSION ARE FULLY UNDERSTOOD AND ACCEPTED.

Signature: _____ Date: _____ SMS.1.121.1109

Patient Home Medication List – Medication Reconciliation

Provided by the Patient/Surrogate
(Include prescriptions, over the counter, herbals, vitamins and birth control pills/patch)

Allergies		
Allergies	☐ NKAS (No Known Allergies or Sensitivities)	☐ Allergies & their reactions
		☐ Latex/Rubber ☐ Adhesive ☐ Environmental ☐ Food (specify above)

Medications	Medication(s)	Dose	Route	Date of last dose 1st Visit	2nd Visit	3rd Visit
			☐ PO ☐ Patch ☐ Injection ☐ Other ______			
			☐ PO ☐ Patch ☐ Injection ☐ Other ______			
			☐ PO ☐ Patch ☐ Injection ☐ Other ______			
			☐ PO ☐ Patch ☐ Injection ☐ Other ______			
			☐ PO ☐ Patch ☐ Injection ☐ Other ______			
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			☐ PO ☐ Patch ☐ Injection ☐ Other ______			
			☐ PO ☐ Patch ☐ Injection ☐ Other ______			
			☐ PO ☐ Patch ☐ Injection ☐ Other ______			

Review the Allergies and Medications for the patient – Healthcare Provider Signature

Date	Preop -	OR -	PACU -
Date	Preop -	OR -	PACU -
Date	Preop -	OR -	PACU -

Patient Label

SURGERY CENTER QUESTIONNAIRE

Please Answer the Following Questions about your Health History

NOTE: This questionnaire may be used for a second visit,
As long as the information is **UPDATED** and the second visit is **within 30 days** of the first visit.

Date of 1st Visit: / /	**Date of 2nd Visit: / /**	**Date of 3rd Visit: / /**

YES	NO	HISTORY	MORE INFORMATION, IF ANSWERED "YES"
		High Blood Pressure	
		Cancers	List -
		Heart	□ Heart Attack □ Heart Failure □ Irregular Heart Beat
			□ Chest Pain □ Mitral Valve Prolapse
			□ Other heart related history -
		Diabetes	
		Thyroid	
		Lungs	□ Asthma □ Tuberculosis □ Emphysema
			□ Chronic Bronchitis □ Other -
		GI Problems	□ Reflux □ Other -
		Liver	□ Hepatitis □ Cirrhosis □ Yellow Jaundice
			□ Other -
		Kidneys	□ Bladder Infections □ Kidney Stones
			□ Other -
		Bleeding or Blood Clots	□ Blood Clots or DVT □ Other -
		Glaucoma	
		Neuro/Muscular	□ Muscle Disorders □ Black Out Spells □ Paralysis
			□ Stroke □ Seizures/Convulsions
			Explain -
		Dental	□ Loose Teeth □ False Teeth □ Dentures
			□ Bridges □ Capped Teeth □ Braces
		Sleep	□ Snoring □ Sleep Apnea
		Family History	Have you had a family member that has had a problem with being put to sleep for an operation?
		Hospitalizations	List any illnesses that required hospitalization -
		Surgeries	List any past surgeries -
		Social	□ Alcohol – Number of times per week
			□ Tobacco – Number of times per day
		Pregnancy	If female, what was the date of last menstrual cycle -
		Recent Illness	□ Cold/Sinus □ Other -
		Vision/Hearing	□ Do you wear contacts? □ Do you wear hearing aids?
		Patient Rights	Are you an organ donor? (State-required information needed)
			Do you have an Advanced Directive?

To be Reviewed by the Healthcare Providers

CONSENT FORM FOR SURGERY/SPECIAL PROCEDURE

I authorize and direct Dr. _____ and the associates or assistants of his/her choice to perform the following operation and/or procedures:

_____

_____

Performing MD signature to confirm correct site/procedure _____

And such additional or alternative therapeutic operations or procedures as his/her or their judgment may dictate on the basis of findings during the course of said operation/procedure.

The performing physician has discussed with and explained to me:

- The nature and purpose of the operation and/or procedure
- The possibility that complications may arise and develop
- The significant risks which may be involved
- The possible alternative methods of treatment
- The prognosis if no treatment is received
- Advance directives (including Do Not Resuscitate orders) are suspended during the operative/special procedure and immediate post operative/special procedure periods

I understand that no warranty or guarantee has been made as to the result of cure. I authorize and direct the above named physician(s) and/or associates or assistants to arrange for provisions of such additional services, as he/she or they deem reasonable and necessary, including, but not limited to:

- The administration and maintenance of anesthesia
- The transfusion of blood
- The performance of services including pathology and radiology, with the following exceptions:

Any tissue or parts surgically removed may be retained or disposed of by the Surgery Center.

I understand that, at my surgeon/physician's discretion, videotaping and/or photographs may be taken during the course of the procedure for documentation purposes, I consent to:

- The admittance of authorized observers to the operating/procedure room
- The videotaping of the operation and/or procedure, provided that my identity is not revealed by such pictures or any descriptive texts accompanying them:

_____

RELEASE OF INFORMATION & CONSENT FOR SURGERY/PROCEDURE:
I authorize the release of medical information to those health care facilities and/or physicians who may be responsible for the patient's follow-up care. I hereby state that I have read and understand this Consent Form, that all questions about the operation/procedure(s) have been answered in a satisfactory manner, and that all blanks were filled in prior to my signature.

SIGNATURE: _____ DATE:_____

RELATIONSHIP: ☐ Self ☐ Other: _____ WITNESS:_____

Time out was conducted after drape and before incision/injection. All team members agreed. Circulator initial _____

MAG Medical Anesthesia Group

Place Patient Label Here

Consent for Anesthesia

I am scheduled for surgery or procedure on _____. Although I may be an outpatient, I agree and consent to admission to the hospital if deemed appropriate by my physician(s). I understand that anesthesia services provided in conjunction with this surgery or procedure will be provided by an Anesthesiologist or Certified Registered Nurse Anesthetist at Medical Anesthesia Group.

I agree Medical Anesthesia Group, its affiliates and agents may use an automated telephone dialing system, and texting, to contact any telephone number, including the cellular telephone number(s) that I provided to the facility upon admission for appointment and payment purposes.

I have read, understood and will comply with all verbal and written instructions. My answers to all questions are true to the best of my knowledge and I have not withheld any information.

I understand that any type of anesthesia, including regional nerve blocks, has associated risks, hazards, and complications. These risks include, but are not limited to, long lasting and permanent injury or damage to my brain, heart, liver, kidneys, vocal cords, larynx, trachea, lungs, teeth, eyes, skin, as well as other organs and body structures, permanent nerve injury or damage, infection, allergic reactions, paralysis and death. ANESTHESIA MEDICATIONS MAKE BIRTH CONTROL PILLS INEFFECTIVE FOR 7 (SEVEN) DAYS. While these risks, hazards, and complications occur infrequently, I understand the possibility they may occur during my surgery or procedure cannot be completely eliminated.

I understand the amount of discomfort and recall during my surgery or procedure depends upon the surgical procedure, the type of anesthesia selected, and each individual patient. Reasonable steps will be taken to minimize discomfort and recall but I understand the risk of discomfort and recall cannot be completely eliminated in my surgery or procedure.

I have read this form completely and have fully discussed the risks, benefits and alternatives associated with the anesthesia to be provided in conjunction with my surgery or procedure with an Anesthesiologist or Certified Registered Nurse Anesthetist at Medical Anesthesia Group. I understand that general, regional (including a nerve block), and sedation anesthesia or a combination thereof may be utilized to provide pain management during and/or after my surgery or procedure. I have been given an opportunity to ask questions and all my questions have been answered to my satisfaction. My signature below indicates I understand the risks, benefits and alternatives associated with the anesthesia to be provided and I hereby give voluntary informed consent to the administration of anesthesia and management of anesthesia during and/or after my surgery or procedure.

READ BEFORE SIGNING.

_____ _____

Signature of patient, parent, legal guardian, or surrogate decision-maker Time / Date

_____

Relationship of person signing for patient

_____

Signature / Title of Witness

_____ _____

Anesthesiologist Signature Time / Date