

North Valley Outpatient Surgery Center

STATEMENT OF PATIENT RIGHTS

In consideration of the basic rights of patients and concern for the well-being and personal dignity, the facility shall endeavor to assure that the following rights are preserved:

- To be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care needs.
- To be free from chemical, physical, and psychological abuse and neglect.
- To refuse or withdrawal consent for treatment or give conditional consent for treatment.
- To have medical and financial records kept in confidence and release of such records shall be written consent of the patient or patient's representative except where permitted by law.
- To be informed of the following:
 - a. Propose surgical and risks involved
 - b. Policy of Advance Directives
 - c. Cost of services prior to obtaining
 - d. Notice of third party coverage including Medicare and AHCCCS coverage grievance process.

If the patient or patient's representative has any concerns about patient rights, safety, or complaints or grievances, please contact Administration at (480) 342-7002. Any patient or patient's representative may submit a grievance without retaliation. If you are not satisfied with the resolution of your complaint, you have the right to contact:

Arizona Department of Health Services
Attn: Licensing Medical Facilities
150 N. 18th Ave., 4th Floor
Phoenix, Arizona 85007
(602) 364-3030

- or -

www.medicare.gov/ombudsman/resources.asp

Date

Patient Signature

North Valley Outpatient Surgery Center

NOTICE OF PRIVACY PRACTICES

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory test and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of North Valley Outpatient Surgery Center. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may be of interest to you.

Fund raising. Unless you request us not to, we will use your name and address to support our fund raising efforts.

Date

Patient Signature

North Valley Outpatient Surgery Center

ADVANCE DIRECTIVES

YOUR RIGHT TO MAKE DECISIONS ABOUT MEDICAL TREATMENT

This form will help explain your rights to participate in health care decisions and how you can plan what should be done when you can't speak for yourself. A federal law requires us to give you this information. The law is intended to increase your control over medicine treatment decisions.

Who decides about my treatment?

Your doctors will give you information and advice about treatment. You have a right to choose. You can say "Yes" to the treatment you want. You can say "No" to the treatment that you do not want even if it might keep you alive longer.

How do I know what I mean?

Your doctor will tell you about your medical condition and about what different treatment can do for you. Many treatments have "side effects". Your doctor must tell you about serious problems that medical treatment is likely to cause you.

What if I am too sick to decide?

If you cannot make treatment decisions, your doctor will ask your closest available relative or friend to help you decide what is best for you. Most of the time, that seems to work. But, sometimes everyone does not agree what to do. That is why it is helpful if you say in advance what you want to happen when you cannot speak for yourself. There are several kinds of "advance directives" that you can use to say what you want and who you want your doctors to listen to in the event this happens.

Who can fill out this form?

You can if you are eighteen (18) years or older and are able to make your own decisions. You do not need a lawyer to fill it out.

Who can I name to make medical decisions when I am unable to do so?

You can choose an adult relative or friend you trust to speak as your "agent" to speak for you when you are too sick to make your own decisions.

How does this person know what I want?

Once you choose someone, talk to that person about what your wishes are. You can also write down in the "Power of Attorney for Health Care" when you would or would not want medical treatment. Talk to your doctor about what you want and give your doctor a copy of the form. Give another copy to the person named as your agent, and bring a copy with you going into a hospital or treatment facility.

Sometimes treatment decisions are hard to make and it truly helps your family and your doctors if they know what you want. The "Power of Attorney" also gives them legal protection when they follow your wishes.

What if I do not have anybody to make decisions for me?

You can still put in writing your wishes about treatment. Documents that do this are often called "living wills" because they take in effect while you are still alive but have become unable to speak for yourself.

When you sign this form, it tells your doctors that you do not want any treatment that would prolong your dying. All life sustaining treatment would be stopped if you were terminally ill and your death was expected soon, or if you were permanently unconscious. However, you would continue to receive treatment to keep you comfortable.

If you have a living will, the doctors must follow your wishes about limiting treatment or turn your care over to another doctor who will. Your doctors are also legally protected when they follow your wishes.

Patient Initials

North Valley Outpatient Surgery Center

ADVANCE DIRECTIVES

YOUR RIGHT TO MAKE DECISIONS ABOUT MEDICAL TREATMENT

If the living will does not suit you, you can fill out a non-statutory living will to state you would or would not want to be treated. There are many different living will forms available or you can write down your wishes on a piece of paper. Your doctors and family can use what you write in deciding about your treatment.

Can I still tell somebody what I want?

You can talk to your doctors and ask them to write down what you have said in your medical chart, and you can talk with your family, but people will be clear about your treatment wishes if you write them down. Your wishes are more likely to be followed if they are written down.

What if I change my mind?

You can change or revoke any of these documents at any time as long as you can communicate your wishes.

Will I still be treated if I do not fill out these forms?

Absolutely, you do not have to fill out any forms if you do not want to. You will get medical treatment regardless. We just want you to know that, if you become too sick to make decisions, someone else will have to make them for you.

Remember that:

A "Power of Attorney" lets you name someone to make treatment decisions for you. It applies to all medical decisions when you are not able to speak for yourself, not just to life-sustaining treatments. Besides by appointing an agent, you can also use the form to say when you would and would not want particular kinds of treatment.

If you do not have someone you want to appoint to make decisions when you are not able to, you can sign a living will to direct that life-prolonging treatment not to be used in certain situations.

If I have an executed Advance Medical Directive, I understand it is my responsibility to provide a copy to the facility.

This certifies I have received information during my pre-operative visit.

Date

Patient Signature

FACILITY POLICY STATEMENT

This Surgery Center supports a patient's right to participate in health care decision making. Through education and inquiry about advance directives, this encouraged patients to communicate their health preferences and values to others. We have formal processes to ensure that your wishes about treatment will be followed and we will not condition the provision of care or otherwise discriminate against anyone based on whether or not you have executed an advance directive.

My signature acknowledges that I have received a copy of our policy and these rights as outlined by the "Patient-Self Determination Act".

TO BE COMPLETED BY FACILITY

_____ I have not executed an Advance Medical Directive at this time and do not want any further information.

_____ Copy provided (copy placed on the left side of Medical Record)

_____ Copy not available; Requested a copy from _____

_____ I do not have an Advance Medical Directive and I would like additional information

Date

Patient Signature

North Valley Outpatient Surgery Center

**NOTICE TO PATIENTS
DISCLOSURE OF PHYSICIAN OWNERSHIP**

As a prospective patient of North Valley Outpatient Surgery Center, we are pleased to inform you of the following:

1. North Valley Outpatient Surgery Center is a physician owned facility and meets the federal definition of a “physician-owned entity. The Center’s ownership information is available to you or your authorized representative upon request.
2. You have the right to choose the provider of your health care services. Therefore, you have the option of using an alternative health care facility other than North Valley Outpatient Surgery Center.
3. You will not be treated differently by your physician if you choose to use an alternative health care facility. If desired, your physician can provide you with information about alternative health care facilities.

If you have any questions regarding the information contained in this Notice to Patients, please feel free to ask your physician or a representative of North Valley Outpatient Surgery Center. We welcome you as a patient and value our relationship with you.

ACKNOWLEDGEMENT OF DISCLOSURE

By signing this Acknowledgment of Disclosure, you acknowledge that you have read and understand the foregoing Notice to Patients regarding physician ownership.

Signature of Patient

Signature of Parent or Guardian (if applicable)

Print Name of Patient

Print Name of Parent or Guardian (if applicable)

Date

Signature Witnessed By

Date

