Urology Specialists
Surgery Center

I have executed an advanced directive or living will (Yes, please provide a copy for your medical record)	☐ Yes	☐ No
I have **not** executed an advanced directive or living will, but would like more information.	☐ Yes	☐ No
I have **not** executed an advanced directive or living will, and would **not** like more information.	☐ Yes	☐ No
I have been given a copy of Official GA State Advanced Directives forms	☐ Yes	☐ No

_____ _____ _____AM/PM

Patient/Witness Signature Date Time

We at Urology Specialists Surgery Center is not an acute care facility; therefore, regardless of the contents of any advance directive or instructions from a healthcare surrogate, if an adverse event occurs during your treatment, we will initiate resuscitative or any other stabilizing measures and transfer you to an acute care setting for further evaluation. Any information regarding current health care directives or health care power of attorney, or living will, will be shared with the facility where you are transferred.

If you have an advance directive, please bring a copy of the advance directive so it may be placed on your chart.

I have received a notification of my rights and responsibilities as a patient which includes information regarding physician ownership of the Surgery Center, Advance Directives, Release of Information, Authorization of Benefits and the Grievance Procedure.

_____ _____ _____AM/PM

Patient/Witness Signature Date Time

UROLOGY SPECIALISTS SURGERY CENTER

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD(S)

I hereby assign to and authorize payment directly to Urology Specialists Surgery Center (the "facility") of all benefits due me under Medicare, Medicaid, or any insurance policy providing benefits for facility charges, for services rendered by the facility.

A photostatic copy of this agreement shall be considered effective and valid as the original.

I irrevocably agree that the facility may disclose, to the extent allowed by law, my medical and financial record to (a) any affiliate of the facility, including entities under contract with same to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to the facility or to me, or any person or entity responsible for all or part of the facility's charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred by the facility or by my physician for continued care; (d) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Health Care Financing Administration, any other governmental or accrediting agency, or their agents or employees.

All facility charges are due and owing prior to services rendered. In consideration of the services to be rendered, to the extent not expressly prohibited by law or by the contract between the facility and my third party payer. I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law. I understand that I am financially responsible for charges not paid within said 60 days and for charges not covered by this assignment. I understand that the facility files for reimbursement from my insurer or other payer as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the facility.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due.

Facility employees are NOT able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

_____ _____

Patient **Date** **Guarantor** **Date**

_____

Witness **Date**

UROLOGY SPECIALISTS SURGERY CENTER
PATIENT RIGHTS

Become informed of your rights as a patient in advance of any procedure or when discontinuing the provision of care. You may appoint a representative to receive this information should you so desire.

Receive as much information about any proposed procedure or treatment as needed in order to give informed consent or to decline the course of a procedure or treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, any alternate course 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.

Knowledge of the name of the physician and professional staff who have primary responsibility for coordinating your procedure and care and the name and professional relationships of other physicians and non-physicians who will participate in your procedure and care.

Receive information from the physician about your medical condition, course of treatment, procedure recommended and prospects for recovery in terms that you can understand.

Participate actively in decisions regarding your medical care and, to the extent permitted by law, this includes the right to request and/or refuse a procedure and/or treatment.

Receive an Advance Directive form if requested. The ambulatory surgery center is not an acute care facility; therefore, regardless of the contents of any advance directive or instructions from a healthcare surrogate, if an adverse event occurs during your treatment, we will initiate resuscitative or any other stabilizing measures and transfer you to an acute care setting for further evaluation. Any information regarding current health care directives or health care power of attorney, or living will, will be shared with the facility where you are transferred.

Reasonable continuity of care and to know in advance the time and location of appointments for procedure and care as well as the physician performing the procedure and/or providing the care.

Be treated with respect, consideration and dignity and to receive considerate and respectful care provided in a safe environment.

Be informed by the physician or designee of the continuing health care requirements following discharge.

Leave the ambulatory surgery center even against the advice of the attending physician.

Expect reasonable safety insofar as the ambulatory surgery center's practice and environment are concerned.
Know that you can express a complaint regarding your care or any violation of your rights, and that you're doing so will not adversely affect the quality of care provided.

Notification of the grievance process. This includes: who to contact to file a grievance, that you will be provided with a written notice of the grievance determination that contains the name of the ambulatory surgery center contact person, the steps taken to investigate the grievance, the results of the grievance investigation and the grievance completion date.

Full disclosure of the privacy policy. Full consideration of your privacy concerning procedures and medical care provided, case discussion, consultation, examination, procedures and treatment are confidential and are conducted discreetly. You have the right to be advised as to the reason for the presence of any individual involved in your healthcare.

Confidential treatment of all communications and records pertaining to your care and visits to the ambulatory surgery center. The patient's written permission shall be obtained before medical records are available to anyone not directly concerned with your care unless production is required by law.

If eligible for Medicare, to know, upon request and in advance of treatment, whether a healthcare provider and/or facility accesses the Medicare assignment rate.

Exercise these rights without regard to age, race, disability, sex or culture, economic, education, or religious background or the source of payment for care given.

Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

PATIENT RESPONSIBILITIES

The care a patient receives depends partially on the patient. Therefore, in addition to a patient's rights, the patient has certain responsibilities as well. These responsibilities are, in the spirit of mutual trust and respect, to:

Provide accurate and complete information about present complaints, past illnesses, hospitalizations, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities, and other matters related to health status.

Make it known whether the course of treatment and what is expected of the patient is clearly understood.

Follow the treatment plan established by the physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.

Provide a responsible adult to transport the patient home from the ambulatory surgery center and remain with the patient for 24 hours if required by the physician.

Keep appointments and notify the ambulatory surgery center or physician when unable to keep an appointment.

Accept responsibility for any actions resulting from the refusal to follow treatment or physician's orders.

Accept and ensure that the financial obligations of care are fulfilled as promptly as possible.

Follow ambulatory surgery center policies and procedures.

Be considerate of the rights of other patients and ambulatory surgery center personnel.

Be respectful of personal property and that of other persons in the ambulatory surgery center.

The ASC strives to provide excellent patient care and service. If you should have a concern or complaint, please tell us so we can work to satisfy your needs. Ask to speak to the Administrator or Medical Director.

PATIENT COMPLAINTS

Patients have the right to register a complaint, in writing, to the Administrator of the surgery center. Please submit complaint to:

ATTN: Administrator
Urology Specialists Surgery Center, LLC
5400 Bowman Road
Macon, Georgia 31201

If the complaint is not resolved to the patient's satisfaction the patient has a right to file a grievance with the Healthcare Facility Regulation Division, Department of Community Health, Complaints Unit for concerns against the surgery center, the Georgia Composite Medical Board concerning the physician or the Professional Licensing Boards Division, Georgia Board of Nursing against any of the nursing staff or Medicare. The patient should either call any of the complaint units or send a written complaint. The patient should provide the physician or surgery center or nurse name, and address and the specific nature of the complaint.

Medicare: www.cms.hhs.gov/center/ombudsman.asp or call 1-800-MEDICARE.

COMPLAINTS AGAINST THE ASC:

Healthcare Facility Regulation Division
Department of Community Health
Attn: Complaints Unit
2 Peachtree Street, N.W., Suite 31-447
Atlanta, Georgia 30303-3142
P: (404) 657-5726; P: (404) 657-5728
ONLINE:
https://services.georgia.gov/dhr/reportfiling/searchFacility.do?action=constituentComplaint

COMPLAINTS AGAINST THE PHYSICIAN:

Georgia Composite Medical Board
Enforcement Unit
2 Peachtree Street, N.W., 36th Floor
Atlanta, Georgia 30303
P: (404) 657-6494; (404) 656-1725
F: (404) 463-6333
ONLINE FORM:
https://versa.medicalboard.georgia.gov/datamart/gadchComplaint.do?from=loginPage
MAILED FORM:
http://www2.files.georgia.gov/GCMB/Files/CP%20Form%20022010.pdf

COMPLAINTS AGAINST NURSING STAFF:

Professional Licensing Boards Division
Georgia Board of Nursing
237 Coliseum Drive
Macon, Georgia 31217-3858
P: (478) 207-2440
ONLINE:
https://secure.sos.state.ga.us/myverification/SubmitComplaint.aspx

HIPAA PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within Urology Specialists Surgery Center, LLC for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of Urology Specialists Surgery Center, LLC receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by Urology Specialists Surgery Center, LLC to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You may be contacted by Urology Specialists Surgery Center, LLC for the purposes of raising funds to support the organization's operations.
- You have the right to restrict the use of your confidential healthcare information. However, Urology Specialists Surgery Center, LLC may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- Urology Specialists Surgery Center, LLC is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.
- Urology Specialists Surgery Center, LLC will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to Urology Specialists Surgery Center, LLC if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to:

COMPLAINTS AGAINST THE ASC:

Healthcare Facility Regulation Division
Department of Community Health
Attn: Complaints Unit
2 Peachtree Street, N.W., Suite 31-447
Atlanta, Georgia 30303-3142
P: (404) 657-5726; P: (404) 657-5728
ONLINE:
https://services.georgia.gov/dhr/reportfiling/searchFacility.do?action=constituentComplaint

COMPLAINTS AGAINST THE PHYSICIAN:

Georgia Composite Medical Board
Enforcement Unit
2 Peachtree Street, N.W., 36th Floor
Atlanta, Georgia 30303
P: (404) 657-6494; (404) 656-1725
F: (404) 463-6333
ONLINE FORM:
https://versa.medicalboard.georgia.gov/datamart/gadchComplaint.do?from=loginPage
MAILED FORM:
http://www2.files.georgia.gov/GCMB/Files/CP%20Form%20022010.pdf

COMPLAINTS AGAINST NURSING STAFF:

Professional Licensing Boards Division
Georgia Board of Nursing
237 Coliseum Drive
Macon, Georgia 31217-3858
P: (478) 207-2440
ONLINE:
https://secure.sos.state.ga.us/myverification/SubmitComplaint.aspx

Medicare: www.cms.hhs.gov/center/ombudsman.asp or call 1-800-MEDICARE.

UROLOGY SPECIALISTS SURGERY CENTER

OWNERSHIP

I understand that the physician(s) on staff at Urology Specialists Surgery Center, LLC, hereinafter ASC, providing medical services are in fact the owners of the facility. Drs. Perkel, Casey, Geary and Anderson each have a 25% ownership interest in the ASC. The surgery center is owned by Urology Specialists Surgery Center, LLC. I understand that I may choose to have my surgery in a facility that is not owned by physicians. I have been given this option and choose to have my surgery at the ASC.

RELEASE OF INFORMATION

The ASC is hereby authorized to request and/or release any medical records, radiographic or diagnostic imaging results, pertinent to the healthcare of the above named patient from or to, but not inclusive of, any insurance carrier, adjustor, attorney, or other health care provider. I understand that the information released to these facilities will be used in furthering or processing claims with the insurance company(s). This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by a physician of the ASC. The information released will not be given, sold, or transferred to any other person not mentioned above, unless required by law. I understand that I am entitled to a photocopy of this authorization upon request.

ASSIGNMENT OF BENEFITS AND MY FINANCIAL RESPONSIBILITY

It is the policy of the ASC to collect payment at the time of visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. However, you are expected to pay any co-pay or deductible at the time of service. If your carrier is out of network, you are expected to pay at time of service, unless other arrangements have been made. I understand that my insurance company may send payments for the rendered services to me. I hereby assign to the ASC all surgical, medical insurance and/or other benefits, if any, otherwise payable to me for the services. I agree to endorse the check(s) over to the ASC. I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud. I hereby authorize and direct payment directly to Urology Specialists Surgery Center, LLC from the obligor of said benefits. Further, I hereby assign and convey Urology Specialists Surgery Center, LLC, unless charges for their services have been paid, so much of any cause of action or right of recovery and any payment proceeds relating thereto, that I may have against any third party and direct my attorney, if one has been retained as well as any person or insurance company obligated to pay damages or restitution to me, to deduct the amount of any outstanding bill for Urology Specialists Surgery Center, LLC any settlement proceeds or other proceeds to be paid directly to me, prior to receiving said proceeds. I understand that payment is due when services are rendered unless prior arrangements have been made. I assign all medical and/or surgical benefits including major medical benefits for services provided to the ASC. This assignment will remain in effect until revoked by me in writing. I am aware that any charges NOT COVERED by my insurance policy are my responsibility. I further understand that should any account with Urology Specialists Surgery Center, LLC be turned over to a collection agency, I will be responsible for any additional interest on my outstanding balance or charges that may be incurred in the collection of my account.

BILLING INFORMATION

The surgery you have had or are about to receive has <u>three (3) separately billable components</u> which consist of:

1) **The professional services of the surgeon,**
2) **The professional services of the Certified Registered Nurse Anesthetist, and**
3) **The facility fee (for use of the surgery center)**

Each of these entities is a separate company and cannot answer billing questions for the other, so please contact the appropriate company for billing related concerns.

GRIEVANCE PROCEDURE

All alleged grievances will be fully documented, investigated and reported to the Administrator of ASC. Any substantiated allegation will be reported to the State and/or Local authority. The grievance documentation will include the process for how the grievance was addressed. The patient will be provided a thorough written notice of the decision, within twenty (20) days of receipt of the grievance. Contact information for filing grievances is included on the Patient Bill of Rights. Patient will be kept up-to-date on the grievance status.

ADVANCE DIRECTIVES

I understand that I will receive an Advance Directive form if requested. The ambulatory surgery center is not an acute care facility; therefore, regardless of the contents of any advance directive or instructions from a healthcare surrogate, if an adverse event occurs during your treatment, we will initiate resuscitative or any other stabilizing measures and transfer you to an acute care setting for further evaluation. Any information regarding current health care directives or health care power of attorney, or living will, will be shared with the facility where you are transferred.

UROLOGY SPECIALISTS
Surgery Center

AUTHORIZATION TO INQUIRE OR APPEAL ON BEHALF OF THE PATIENT

Member Name:_____

Member Policy #:_____

Member Group #:_____

DATE(S) OF SERVICE: _____

I hereby give permission to the below listed facility to inquire or appeal claims on my behalf. I understand that this provider may be considered out-of-network and I am aware of my out-of-network benefits.

Urology Specialists Surgery Center

Signature_____ Date _____

Sweet Dreams Nurse Anesthesia (Medfin)

Anesthesia is commonly a covered component of your surgery. As a courtesy to you, the bill/claim for your anesthesia services will be filed directly to your primary insurance carrier. We have accepted assignment of benefits and your insurance carrier should send the payment directly to our remittance address. If we have a secondary insurance on file, we will file a claim on your behalf for the amount not paid by your primary insurance. If no secondary insurance was provided at the time of service we will send you a statement for the co-insurance due as determined by your insurance carrier.

In the event that Sweet Dreams Nurse Anesthesia, INC is not a participant within your insurance plan, we will work with your carrier through appeal efforts to insure that you are not penalized for our non-participating (aka out-of-network) status. The amount you may owe will be within the "Reasonable and Customary" benefit rate limits in your area. We are often able to negotiate with your insurer to allow minimal or no out-of-pocket anesthesia costs to you due to our out-of-network status.

In the event that your balance due for our services differs from your explanation of benefits based on an adjustment by us, please contact your insurance company to alert them of the reduction. It is the member's responsibility to contact their insurance carrier to report any adjustments or reductions applied to the patient portion due. This allows them to update their records to reflect any differences in your Out-of-Network deductible, out-of-pocket expenses and catastrophic cap for the benefit year.

If you're insurance carrier sends payment directly to you, please endorse the back of the check and list "Pay to the order of" Sweet Dreams Nurse Anesthesia, INC above your signature. **OR** write a personal check for the amount received. Please forward payment to the name and address listed below. We will also require a copy of the original explanation of benefits received with payment. If you have any questions or concerns, please contact our billing company at **1-877-360-1566**. You may also contact our Administrative Office at **1-888-728-0882** extension 111.

Please read & ask any questions that you may have so the content of this letter is understood at the time of service.

You will receive an explanation of benefits from your carrier and until a statement is received by you from Sweet Dreams Nurse Anesthesia, INC please do not make any payments to us until you are notified in writing. If you are paid directly by your carrier please contact us immediately.

Respectfully,

Sweet Dreams Nurse Anesthesia
PO Box 4380
Alpharetta, GA 30023

Patient Signature **Date** **Witness Signature** **Date**

UROLOGY SPECIALISTS
Surgery Center

We will file a claim on your behalf with your insurance carrier. Please be aware that Blue Cross Blue Shield will likely send our payment to you directly. Even though Blue Cross Blue Shield has addressed this payment to you as the patient or insured, these funds are for the services that Urology Specialists Surgery Center provided to you, and are intended to cover the expense of your surgery at the surgery center. In the event that you receive this payment, it is important that you turn the check into our office within 7 days of receipt. You can endorse the check payable to Urology Specialists Surgery Center and either deliver it to our facility or mail it directly to our remittance address: **7 Arnage Blvd., Chesterfield, MO 63005**.
Blue Cross Blue Shield makes payment directly to the patient for services provided by an out-of-network provider. After you have surrendered the payment and accompanying paperwork to our office, your balance will be adjusted to account for the in-network versus out-of-network benefit difference. Failure to surrender the payment will make you ineligible for any discounts or adjustments, and the full charges will become your responsibility. If you then fail to pay your full balance within 30 days of the first patient statement, your account may be turned over to our outside collection agency. This may result in a suit against you for payment in full, along with adverse reporting to the credit bureaus.

I, _____, have read the above statements and understand my responsibility to turn over the payment I receive from my insurance carrier, to Urology Specialists Surgery Center, within 7 days of receipt, regardless of notification by Urology Specialists Surgery Center. I further understand that failure to comply with this agreement will make me ineligible for any discounts or adjustment to my charges and I will be responsible for the full balance.

Signature_____ Date_____