Surgery of Tomorrow

Patient Instruction Packet

Please read the information in this packet at least 5 DAYS before your scheduled appointment.

PLEASE COMPLETE THE FORMS ON PAGES 10 THRU 19, AND BRING THEM WITH YOU ON THE DAY OF YOUR APPOINTMENT ALONG WITH YOUR INSURANCE CARD AND PHOTO IDENTIFICATION.

Surgery of Tomorrow
1766 E 12th Street
Brooklyn, NY 11229
P - 718-375-2200
F –
www.surgeryoftomorrow.com

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Welcome Notice

Welcome to Surgery of Tomorrow (SOT). SOT is a private, freestanding, ambulatory surgery center located in Brooklyn, New York. The Center provides an appropriate setting in which members of its medical staff may perform outpatient ambulatory gynecological procedures on their patients, consistent with the clinical privileges granted to each medical staff member by the Operator. The Center will establish and maintain the highest professional standards and commitment to excellence in care and considerate of the specific needs of our culturally diverse patient population.

In order to promote the highest quality of ambulatory endoscopic services, the Center will maintain a physical environment conducive to the provision of safe, efficient procedures; ensure that safe, effective and state of the art equipment and supplies are available for use by the Center's physicians and clinical staff; recruit, hire, affiliate with and maintain relationships with qualified, skilled physicians, other clinical staff, administrative staff, support staff and other providers; and provide effective continuing education and quality assurance/risk management programs. In addition, we serve as a resource for patients, families and physicians in the education and gynecological treatment.

It is the mission of the Center to serve all persons in need of ambulatory gynecological services, regardless of age, color, race, creed, national origin, religion, sex, sexual orientation, marital status, disability, payer source, or any other personal characteristics or qualification including the ability to pay.

HIPAA 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.

This Notice of Privacy Practices describes how we 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 condition and related health care services.

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 pay your health care bills, to support the operation of the physician's practice, and any other use required 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, 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.

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

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, employee review, training of medical students, licensing, fundraising, 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 where 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, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required 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, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when

required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under 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 the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information; we will charge you $0.75 per page copied. – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. 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 or 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. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication 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 request an amendment to 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 – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

DIRECTIONS TO SOT

From Manhattan:

Take Hugh L. Carey from Manhattan, Merge onto I-278 W- Brooklyn Queens EXPY toward Verrazano Bridge, DO NOT TAKE VERRAZANO BRIDGE – Take exit 24 for NY-27 E/ Prospect Expy. Continue onto NY-27/Prospect Expy. Continue onto Ocean Pkwy. Turn left on Quentin Road, and right on E 12th Street.

From Long Island:

North Shore:
Take Northern Pkwy W, Take Cross Island Pkwy to Belt Parkway W (OR) Take LIE towards New York, Take Cross Island Pkwy to Belt Parkway W ...

South Shore:
Take Southern State Pkwy straight to Belt Pkwy W. ...

Take the Belt Parkway until exit 8 Coney Island Ave; Turn left onto Shore Parkway. Stay on Shore Parkway Service Road. Make a right onto Coney Island Ave, Right on Kings Hwy, right onto E 12th Street.

From New Jersey:

Take Goethals Bridge to Staten Island. Merge onto I-278 E- toward Verrazano Bridge, Keep left to take Belt Pkwy E. Take Coney Island Ave Exit. But stay straight on Service Road and go to Guider Ave, make right on Guider Avenue and then left on Coney Island Avenue. Turn right on Kings Hwy. Turn right on E 12th Street.

From Queens:

EITHER 1. Take Cross Island Parkway South...OR 2. Take Van Wyck Expy South to Belt Parkway West, Take exit 8-Coney Island Ave; Turn left onto Shore Parkway. Stay on Shore Parkway Service Road. Make a right onto Coney Island Ave, Right on Kings Hwy, right onto E 12th Street.

PATIENT ESCORT POLICY

YOU MUST HAVE SOMEONE PICK YOU UP AFTER THE PROCEDURE

As a matter of patient safety, Surgery of Tomorrow enforces the New York State Ambulatory Surgical Center **requirement that all patients having a procedure in our facility have an escort,** that is, a companion, family member or friend, to accompany you home following your procedure.

If you do not have someone to escort you after the procedure, please contact the Visiting Nurse Services of New York (888 943-8435) to arrange for a care partner to accompany you home from your procedure.

For additional information and to make arrangements for a care partner, you can visit the following website:

www.partnersincareny.org.

Or e-mail:

par_intake@vnsny.org.

Please note that your procedure cannot be performed unless your escort is verified.

Thank you for your cooperation.

PERSONAL POSSESSIONS POLICY

Surgery of Tomorrow will provide you with a handbag to store your personal belongings during the procedure.

Please **DO NOT** wear jewelry, **DO NOT** bring laptops, **DO NOT** bring iPods or any other valuables when you come to the Center.

Please note that Surgery of Tomorrow assumes no responsibility for lost, stolen, or misplaced items.

Thank you for your cooperation.

SURGERY OF TOMORROW

PATIENT REGISTRATION

Today's Date _____ Date of Birth _____ Age _____ Social Security# _____

Patient Name _____ Gender M F Marital Status S M W D
(First Name) (MI) (Last Name)

Address _____
(Street) (Apt#) (City) (State) (Zip Code)(County)

Home Phone _____ Cell Phone _____ Alternate Phone _____ E-mail Address _____

Ethnicity – Do you consider yourself Hispanic/Latino? Y-☐ N -☐ Declined-☐ Unavailable/Unknown-☐ Primary Language _____

Race – Which category best describes your race? American Indian/Alaskan Native-☐ Asian-☐ Black or African American-☐ White-☐

Native Hawaiian/Pacific Islander-☐ Multiracial-☐ Declined-☐ Unavailable/Unknown-☐

Emergency Contact: **Name:** _____ **Telephone:** _____ **Relationship:** _____

Person that will escort you upon discharge from the Center: **Name:** _____ **Telephone #** _____

Employer _____ Occupation _____ Work Phone _____

Address _____
(Street) (City) (State) (Zip Code)

****

Send Report to Dr.: _____ Address _____

Referring Physician Telephone _____ Referring Physician Fax _____

****

Do you have allergies to Latex? ☐ Yes ☐ No

Allergies to food? ☐ Yes ☐ No [if yes, please list] _____

Allergies to medications? ☐ Yes ☐ No [if yes, please list drug names] _____

****

Primary Insurance Company Name _____ ☐ Hosp ☐ Medical Ins Phone # _____

Address _____ Group # _____ ID # _____

Name of Insured _____ Date of Birth _____ SS # _____ Relationship _____

Secondary Ins. Company Name _____ ☐ Hosp ☐ Medical Ins Phone # _____

Address _____ Group # _____ ID # _____

Name of Insured _____ DOB _____ SSN# _____ Relationship _____

I, the undersigned, have insurance with _____ and assign benefits directly to the provider for all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Patient's signature: _____

Do You Have A Health Care Proxy ☐ No ☐ Yes If Yes, Type: _____ Copy Provided? ☐ N/A ☐ No ☐ Yes

****

By signing below, I acknowledge receiving a copy of the Center's Notice of Privacy Practices and the Patient's Bill of Rights and Responsibilities.

Patient's Signature: _____

If an interpreter is necessary, please sign below indicating the patient understands and agrees to the terms herein.

Interpreter's Signature: _____

SURGERY OF TOMORROW

PRE-PROCEDURE QUESTIONNAIRE

NAME: _____ ***REFERRING MD:*** _____

1. Do you have any other medical conditions we should be aware of? ☐ Yes ☐ No
   If yes, please explain _____
2. Do you take any medication regularly? ☐ Yes ☐ No
3. Do you have any allergies to medications or drugs? ☐ Yes ☐ No
   If yes, please list. _____
4. Do you have any food allergies? i.e. eggs or soy? ☐ Yes ☐ No
5. Do you take the aspirin products on a regular basis? ☐ Yes ☐ No
   If yes, these products must be discontinued. Please consult your physician.
6. Do you take non-steroidal anti-inflammatory on a regular? ☐ Yes ☐ No
   (i.e*Advil, Motrin, Aleve, Naprosyn, Moibic, Clinoril, Celebrex)*
   If yes, these products must be discontinued. Please consult your physician.
7. Do you take Coumadin or any other anti-coagulant-Blood Thinners medications? ☐ Yes ☐ No
8. Do you have diabetes? ☐ Yes ☐ No
9. Do you take insulin? ☐ Yes ☐ No
10. Have you ever been told that you have a heart condition? ☐ Yes ☐ No
    If yes, please explain _____
11. Have you ever been told to take antibiotics before a procedure? ☐ Yes ☐ No
    If yes have you taken your antibiotics prior to procedure? ☐ Yes ☐ No
12. Have you ever had a bleeding problem? ☐ Yes ☐ No
13. Have you ever had surgery? ☐ Yes ☐ No
    If yes, please explain. _____
14. Have you ever had any problems with anesthesia? ☐ Yes ☐ No
    If yes, please explain. _____
15. Have you ever had a gynecological procedure? ☐ Yes ☐ No

    *If yes, please provide the details*_____
16. Is there any other information we should know about? ☐ Yes ☐ No

Completed By _____ Date: _____

CENTER PERSONNEL

[ ] No Pre-Procedure Required _____

[ ] Pre –Procedure Testing Needed (specify) _____

Reviewed By: _____ **Date:** _____
Signature/Title

SURGERY OF TOMORROW

MEDICATION LIST AND RECONCILLIATION

Name _____ Date _____

Physician _____

Please list all medications you are currently taking and include the dose.

Medication Name	Dose (i.e. mgs.) Frequency	Date of Last Dose

FOR DOCTOR'S USE ONLY (Please check)
CONTINUE WITH PREVIOUS MEDICATION YES NO

Changes to Medications

Name	Dose (i.e. mgs.)	Number of times per day

_____ PHYSICIAN

_____ NURSE

SURGERY OF TOMORROW

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT

Name: _____ Med. Rec. #: _____

Physician: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct the above named medical facility, having treated me, to release governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I also authorize SURGERY OF TOMORROW, to release medical information in the event of any emergency transfer to an Acute Care Facility.

If I am transferred to or admitted to other institutions in relation to my procedure, I authorize the release of all my medical records pertaining to that transfer or admission to SURGERY OF TOMORROW.

_____ _____

Signature of Patient or Authorized Representative Date

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to the above named medical facility sufficient monies and/or benefits to which I may be entitled for government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent.

I, the undersigned, have insurance with _____ and assign benefits directly to the provider for all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Patient or Authorized Representative Date

CONSENT FOR LABORATORY BILLING

During the course of your procedure, it may be necessary for your physician to obtain and send tissue samples, blood samples or request other laboratory testing. New York State requires clinical laboratories to directly bill patients for their testing services. In other words, they may not present a bill for its services to any person other than the person who is the recipient of the services, or that person's legal representative. Therefore, it is necessary for the Center to receive authorization from the Patient in order for us to allow the laboratory to bill your insurance company for you. If you do not want the laboratory to bill your insurance company, than billing services will go directly to you as the Patient.
Please complete and sign below so that we may direct this issue in the proper manner. Thank you for your cooperation.

[ ] Yes, I am giving the laboratory permission to bill my insurance company

[ ] No, I do not give the laboratory permission to bill my insurance company. I am aware that I am responsible for the payment of services directly to the laboratory.

_____ _____

Signature of Patient or Authorized Representative Date

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER Tile XVIII of The Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician organization to submit a claim to Medicare for payment to me.

_____ _____

Signature of Patient or Authorized Representative Date

*The signature of the patient must be obtained unless the patient is an un-emancipated minor under the age of 18 or is otherwise incompetent to sign.

POLICY ON ADVANCED DIRECTIVES LIVING WILL AND DO NOT RESUSCITATE (DNR)

Do you have *Advanced Directives? YES ☐ NO ☐

Due to the ambulatory nature of your procedure and of this facility, we will not honor Advanced Directives, Living wills or Do Not Resuscitate orders for the short time that you are here as a patient. If you wish to maintain your status during your procedure, then you will have the option of having the procedure done in another facility that accepts this status. In signing this form you are agreeing to the postponement of your directives from the time of your arrival until you leave the facility. If you do not possess one of the above forms please sign below acknowledging that you know the centers policies related to Advanced Directives.

Patient's Signature or Legal Guardian _____ **Date** _____

Print Patient's Name _____

Witness (Sign and Print) _____ **Date** _____

**What kind of medical care would you want if you were too ill or hurt to express your wishes? Advance Directives are legal documents that allow you to spell out your decisions about end-of-life care ahead of time. They give you a way to tell your wishes to family, friends, and health care professionals and to avoid confusion later on.*

Surgery of Tomorrow
GENERAL PRE OPERATIVE INSTRUCTIONS

During the two-week period preceding and for two weeks following your surgery:

- **DO NOT TAKE ANY ASPIRIN OR PRODUCTS CONTAINING NON-STEROIDAL ANTI-INLAMMATORY INGREDIENTS, e.g., Advil®, Motrin®, Aspirin®, Bufferin®, etc. Please note that many over-the-counter medications contain aspirin and/or non-steroidal anti-inflammatory ingredients. Consult the attached sheet for a comprehensive list of products to be avoided. If you regularly take aspirin, please inform your doctor. For management of headaches and pain during this four-week period, you may use Tylenol® and Tylenol Extra Strength®.**
- **DO NOT TAKE ANY HERBAL MEDICATIONS OR NUTRITIONAL SUPPLEMENTS. Please see the list of medication and herbal supplements below.**
- **Please notify the doctor or staff if you develop any symptoms such as a cold, sore throat, fever, or cough prior to your surgery.**
- **Please fill all prescriptions prior to surgery, so that they will be on hand.**

The morning of surgery:

- **Please make a list of the names and dosages of any medications you are currently taking. You may take the CUSTOMARY MORNING MEDICATIONS with a sip of water excluding ASPIRIN containing medication.**
- **DO NOT EAT OR DRINK ANYTHING FOR 6 HOURS PRIOR TO PROCEDURE! This includes coffee, tea, or liquids of any kind. You may brush your teeth and use mouthwash, if you like, but do not swallow any of the liquid.**
- **You may bathe or shower as usual but do not apply any makeup, hairspray, or other grooming products to your skin or hair.**
- **Dress in loose-fitting, comfortable clothing and shoes. Avoid pullover shirts.**
- **Please leave valuables such as watches, jewelry, credit cards, etc. at home.**
- **Be sure to arrive at the facility on time, If you realize that you are going to be late the day of surgery, please inform the facility immediately.**
- **You must have a responsible adult available to drive you home and care for you for the next 24 hours.**

Medications to Avoid Before and After Surgery

If you are taking any medications on this list please stop taking them at least ten days prior to your surgery. If you have minor pain or headache in the ten days leading up to your surgery, you may take Tylenol, since this does not affect blood clotting.

All Non-steroidal anti-inflammatory medications

Advil	Aleve	Fiorinal	Ibuprofen	Motrin	Naproxen	Relafen	Ryfen
Anaprox	Arthrotec	Ketaprofen	Orudis	Cataflan	Volteren	Toradol	Nuprin
Ecotrin	Excedrin	Dapro		Pamprin		Zorprin	

***Patients may take Celebrex or Vioxx

Aspirin or Aspirin containing products

Alka Seltzer	Compound 65	Percodan	Norgesic
Anacin	Ascriptin	Darvon	Soma Compound

MAO inhibitors

Marplan	Nardil	Parnate

Antiplatelets/Anticoagulants

Coumadin	Persantine	Ticlid
Heparin	Plavix	Warfarin

Other Medications: All herbal medications Vitamin E

Patient's Signature: _____ Date: _____

PATIENT SELF-DETERMINATION ACT/ADVANCE DIRECTIVES

Surgery of Tomorrow supports each patient's right to develop an advance directive; the Center will not condition the provision of care or discriminate against an individual based on whether or not an advance directive has been executed; and will provide education for its staff, patients and the community, as applicable, related to the patient self-determination act/advance directives.

NOTICE OF LIMITATION – ***Surgery of Tomorrow will always attempt to resuscitate a patient and transfer that patient to a hospital in the event of deterioration.***

If you are interested you may request resource information regarding self-determination. The information includes:

- The description of state law prepared by the Department of Health entitled, "Planning In Advance For Your Medical Treatment".
- The pamphlet prepared by the department of health entitled, "Appointing Your Health Care Agent – New York State's Proxy Law".
- A model "New York Living Will".
- The fact sheet entitled, "Deciding About CPR Do Not Resuscitate Orders (DNR)".
- A handout entitled, "Ten Basic Questions And Answers For Consumers On The Patient Self-Determination Act".
- A handout entitled, "Definitions For A Health Care Proxy".

Our staff will inquire and document your present status concerning advance directives during the pre-procedure assessment in the medical record.

If you have executed an advance directive and have brought a copy, this copy will be filed in your medical record.

If copies are not immediately available, the types of advance directives and the name and address of the healthcare agent are obtained and documented in your medical record.

If you request additional information or wish to make an advance directive, the Center will supply you with appropriate information and direction.

The Center will comply with the health care decisions made in good faith by a health care agent to the same extent as decisions made by a competent adult.

OWNERSHIP DISCLOSURE

Due to concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, New York State passed a law, prohibiting the physician, with certain exceptions, from referring you for clinical laboratory pharmacy or imaging services to a facility in which the physician or his/her immediate family members have a financial interest. If any of the exceptions in the law apply, or if he/she is referring you for other than clinical laboratory, pharmacy, or imaging services, he/she can make the referral under one condition. The condition is that he/she disclose this financial interest and tell you about alternative places to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care.

For more information about alternative providers, please ask your physician, or his/her staff. They will provide you with names and addresses of places best suited to your individual needs that are nearest to your home or place of work.

Statutory authority; *Public health law, §238 a (10)*

The Following Persons/Physicians Are The Owners Of The Center:
Gregory Shifrin, MD
Ella Shifrin

Financial Policy

Surgery of Tomorrow, SOT, is a for-profit gynecological facility dedicated to providing gynecologists and patients a safe and effective environment for the performance of procedures. The facility will bill an appropriate "facility fee" for the performance of gynecological procedures: Physicians who use the facility, including gynecologists and anesthesiology will bill a separate "professional fee" to be paid directly to themselves. This fee has no relationship to the facility payment other than they are generated at the same procedure. Billing, payment, collection and participation with carriers may differ considerably between the facility and physician involved in the procedures at the facility.

A professional attitude shall be used whenever communicating with patients and insurance companies regarding payment for services rendered. Appropriate staff will assure that the patient understands the implications of his insurance coverage, if any and the resulting personal financial obligation and responsibility for payment for services rendered.

As you know, the world of health insurance has become increasingly confusing and complex for patients and physicians alike. For this reason, we would like to bring to your attention that we are legally required to bill you for any applicable co-payments or co-insurance and/or deductibles which your insurance plan requires you to personally pay under the terms of your insurance policy according to the State of New York Insurance Department opinion see www.ins.state.ny.us/ogco2003/rg030409.htm.

The Federal and State governmental agencies that oversee the health insurance industry have consistently taken the position that the routine waiver of co-payments and co-insurance by healthcare providers may constitute insurance fraud by the insured and the physician. Within 6 months of receiving a response from your carrier, you will receive a "balance bill". These amounts reflect that portion of our facility fees which were not paid by your insurance company and that remain as your personal responsibility. According to the State of New York Insurance Department opinion referenced above, a decision in the exercise of business judgment by a physician not to pursue the full legal remedies available to collect a debt would not constitute insurance fraud. If payment of your full outstanding balance is not financially feasible for you at this time, please call our office and we will try to work out a mutually-agreeable payment plan that you can afford to pay over a reasonable period of time.

For patients who have a sizable financial obligation after payment by insurance, or for patients who have no insurance coverage, a payment contract or the use of a credit card may offer the opportunity to satisfy the financial obligation. For those patients wishing to satisfy their balance due via a financial agreement, the patient or responsible party will be required to sign a contract prior to the procedure. Patient or responsible party will be given a copy of the signed agreement, and the original will be maintained by the Accounts Receivable Office.

SURGERY OF TOMORROW

PATIENT RIGHTS AND RESPONSIBILITIES

The Patient Has a Right to:

1. Receive the care necessary to regain or maintain his or her maximum state of health.
2. Expect personnel who care for the patient to be friendly, considerate, and respectful and qualified through education and experience, as well as perform the services for which they are responsible with the highest quality of service.
3. Expect full recognition of individuality, including personal privacy in treatment and care. In addition, all communications and records will be kept confidential.
4. Complete information, to the extent known by the physician, regarding diagnosis, treatment, procedure and prognosis, as well as alternate treatments or procedures and the possible risks and side effects associated with treatment and procedure.
5. 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.
6. Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.
7. Make informed decisions regarding his or her care.
8. Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility.
9. Approve or refuse the release of medical records to any individual outside the facility, except in case of transfer to another facility, or as required by law or third-party payment contract.
10. Refuse to take part in research/educational projects. If deciding whether or not to participate, you have the right to a full explanation.
11. Express grievances/complaints and suggestions at any time.
12. Assistance in changing primary or specialty physicians.
13. Provide patient access to and/or copies of his or her individual medical records and receive an itemized bill and explanation of all charges upon request.
14. Be informed as to the facility's policy regarding advance directives/living wills.
15. Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the patient transfer.
16. Have an assessment and regular reassessment of pain.
17. Education of patients and families, when appropriate, regarding their roles in managing pain, as well as potential limitations and side effects of pain treatment, if applicable.
18. Have their personal, cultural, spiritual and/or ethnic beliefs considered when communicating to them and their families about pain management and their overall care.

The Patient Has a Responsibility to:

1. Being considerate of other patients and personnel and for assisting in the control of noise and other distractions.
2. Respecting the property of others and the facility and abiding by no smoking rules.
3. Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.
4. Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.
5. Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
6. Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting the right to care at the facility and is responsible for the outcome.
7. Promptly fulfilling his or her financial obligations to the facility.
8. Payment to facility for copies of the medical records the patient may request.
9. Identifying any patient safety concerns.

These rights and responsibilities outline the basic concepts of service here at the ASC. If you believe, at any time, our staff has not met one or more of the statements during your care here, please ask to speak to the Medical Director or the Administrator. We will make every attempt to understand your complaint/concern. We will correct the issue you have if it is within our control and you will receive a response.

Office of the Medicare Beneficiary Ombudsman

Visit **www.medicare.gov** *or call* **1.800.MEDICARE (1.800.633.4227)** *or use* **www.cms.hhs.gov/center/ombudsman**

New York State Department of Health's Metropolitan Area Regional Office (MARO) at 800 804-5447 *Grievances or safety concerns about our outpatient facility should be referred to our Medical Director or Administrator, 718.954.3535*

SURGERY OF TOMORROW

Patient Acknowledgment of Advance Notices

I hereby acknowledge receipt of the Center's **HIPAA Notices of Privacy Practices** and acknowledge that the Center may use and disclose my health information for the purposes of treating me, obtaining payment for services rendered to me and performing routine healthcare operations and services in the Center.

By signing below, I hereby acknowledge that I received written the notice of the **Patient's Bill of Rights and Responsibilities** prior to the start of my procedure;

I hereby acknowledge that I received a written **Ownership Disclosure** listing the physicians who have financial interest or ownership in the ASC facility;

I hereby acknowledge that I was offered written information concerning **Advance Directives**;

I understand that I am **required** to bring an **Escort** to take me home on the day of the procedure;

I have received a copy of the **Financial Policy** and I understand that I may be financially responsible for any outpatient facility charges, as outlined in my insurance coverage for copayments, coinsurance and deductibles.

First Name M.I. **Last Name**

Signature Date

Witness Date

Interpreter Date

Surgery of Tomorrow

GENDER: DOB:
ACCOUNT NUMBER:
DOCTOR'S NAME:
DOS:

CONDITIONS OF ADMISSION

Patient's Name:_____

CONSENT TO MEDICAL AND SURGICAL PROCEDURES

The undersigned consents to the procedures that may be performed during this outpatient visit, including emergency treatment or services, which may include but are not limited to laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, anesthesia, or Surgical Center services rendered the patient under the general and special instructions of the patient's physician or surgeon.

PHYSICIANS ARE INDEPENDENT CONTRACTORS

All physicians and surgeons furnishing services to the patient, including the pathologist, anesthesiologist and the like, are independent contractors and are not employees or agents of the Surgical Center. Some of these physicians will bill separately for their services.

The patient is under the care and supervision of his/her attending physician and it is the responsibility of the Surgical Center and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or Surgical Center services rendered to the patient under the general and special instructions of the physician.

ADVANCE DIRECTIVES

Surgery of Tomorrow encourages its patients to consider end of life decisions, and to develop an advanced directive as appropriate, however, due to the limited scope of service and acuity of the patient population, during treatment at Surgery of Tomorrow, advance directives will not be honored. If you require resuscitative services, life support services will be provided by facility staff until emergency services transports you to an appropriate emergency receiving facility.

PERSONAL BELONGINGS

It is understood and agreed that the Surgical Center maintains lockers for the safekeeping of money and valuables, however the Surgical Center shall not be liable for the loss or damages to any personal property of valuables kept in the lockers or otherwise.

Surgery of Tomorrow

ADER: DOB:
ACCOUNT NUMBER:
DOCTOR'S NAME:
DOS:

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Surgical Center in accordance with the regular rates and terms of the Surgical Center, including its financial assistance policies. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the Surgical Center of any insurance benefits otherwise payable to or on behalf of the patients for outpatient services, including emergency services if rendered, and to Dr. Gregory Shifrin, OB/GYN, PC services. It is agreed that payment to the Surgical Center, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not paid pursuant to this agreement. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine the benefits payable for related services.

HEALTH PLAN OBLIGATION

This Surgical Center maintains a list of health plans with which it contracts. A list of such plans is available upon request from the financial office. The Surgical Center has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full charges of all covered services rendered to him/her by the Surgical Center if he/she belongs to a plan which does not appear on the above mentioned list.

By signing this form, I acknowledge that Dr. Shifrin is the owner of Surgery of Tomorrow and that I am under no obligation to have my surgery at this facility, and that I am free to choose an alternative surgical facility and provider.

ADVANCED DIRECTIVE

Do you have an Advanced Directive? YES/NO (Circle One)

If yes, did you bring your Advanced Directive? YES/NO (Circle One)

Date:_____ Time:_____ AM/PM

_____

Signature of Patient/Conservator/Guardian

Surgery of Tomorrow

..DER: DOB:
ACCOUNT NUMBER:
DOCTOR'S NAME:
DOS:

If signed by anyone other than patient, indicate relationship: _____

Witness:_____

Financial Responsibility Agreement by Person Other Than the Patient of the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Obligation provisions above.

Date:_____ Time:_____ AM/PM

_____
Signature of Financially Responsible Party

Witness:_____

A COPY OF THIS DOCUMENT SHOULD BE GIVEN TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT.