NORTHWEST GA ORTHOPAEDIC SURGERY CENTER
NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____ _____
Name of Patient Signature of Patient

_____ / _____ / _____
Date Signed

_____ _____
Name Patient's Personal Representative Signature of Patient's Personal Representative

_____ / _____ / _____
Date Signed

FOR INTERNAL USE ONLY

_____ _____
Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgment could not be obtained:

☐ Patient was unable to sign.
☐ Patient refused to sign.
☐ Other _____

December 2018 (Version: As noted on NPP) ____/____/____ (Date: As noted on NPP)

Northwest Georgia Orthopaedic Surgery Center
2550 Windy Hill Road, Suite 218
Marietta, GA 30067
(770) 953-8058 Fax: (770) 690-9796

PATIENT RIGHTS

- Receive access to equal medical treatment and accommodations regardless of race, creed, sex, national origin, religion or sources of payment for care.
- Be fully informed and have complete information, to the extent known by the physician, regarding diagnosis, treatment, procedure and prognosis, as well as the risks and side effects associated with treatment and procedure prior to the procedure.
- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice grievances regarding treatment or care that is (or fails to be) furnished.
- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.
- Receive the care necessary to regain or maintain his or her maximum state of health and if necessary, cope with death.
- Know the identity of persons providing care, treatment or services and, upon request, be informed of the credentials of healthcare providers.
- Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience, as well as perform the services for which they are responsible with the highest quality of services.
- Be fully informed of the scope of services available at the facility, provisions for after-hours care and emergency care and related fees for services rendered.
- 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.
- Make informed decisions regarding his or her care.
- 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.
- Approve or refuse the release of medical records to any individual outside the facility, or as required by law or third party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care of treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time.
- Access to and/or copies of his/her medical records.
- Be informed as to the facility's policy regarding advance directives/living wills.
- Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the patient transfer.
- Express those spiritual beliefs and cultural practices that do not harm or interfere with the planned course of medical therapy for the patient.
- Expect the facility to agree to comply with Federal Civil Rights Laws that assure it will provide interpretation for individuals who are not proficient in English.
- Have an assessment and regular assessment of pain.
- Education of patients and families, when appropriate, regarding their roles in managing pain.
- To change providers if other qualified providers are available.

If a patient is adjudged incompetent under applicable state health and safety 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 designated by the patient in accordance with state laws may exercise the patient's rights to the extent allowed by state law.

PATIENT RESPONSIBILITIES

- Be considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the facility.
- Behave respectfully toward all health care professionals and staff, as well as other patients and visitors.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.
- Follow the agreed-upon treatment plan prescribed by his/her provider and participate in his/her care.
- Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.
- Providing care givers with the most accurate, honest, and complete information to the best of his/her ability regarding present complaints, symptoms, past illnesses procedures and hospitalizations, any medications including over-the-counter products and dietary supplements, and any allergies or sensitivities, unexpected changes in the patient's condition or any other patient health matters.

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- Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting to care at the facility.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Provide payment to center for any copies of medical records that he/she may request.
- Identifying any patient safety concerns.
- Provide a responsible adult to provide transportation home and to remain with them as directed by the provider or as indicated on discharge instructions.

PATIENT COMPLAINT OR GRIEVANCE

If you should have a concern or complaint regarding any services, treatment or care that is or fails to be rendered at our Center, please let us know while you are here so that we may have the opportunity to improve. You may also contact the facility Administrator by phone at (770) 953-8058 or by mail:

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Marietta, GA 30067

Complaints and grievances may also be filed through the:
State of Georgia, Department of Community Health
Healthcare Facility Regulation Division
Attn: Complaint Intake Unit
2 Peachtree St., NW, Suite 31-447
Atlanta, GA 30303-3142
(404) 657-5700

AAAHC-Accreditation Association for Ambulatory Health Care
Email: info@aaahc.org
Website: http://www.aaahc.org
Phone: 847-853-6060

For Medicare beneficiaries:
Palmetto GBA
P. O. Box 100142
Columbia, SC 29202
1-866-238-9652

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Call 1-800-633-4227 or visit the Ombudsman's webpage on the web at:

http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

ADVANCE DIRECTIVE NOTIFICATION

In the State of Georgia, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to make decisions or unable to communicate decisions. Northwest Georgia Orthopaedic Surgery Center respects and upholds those rights.

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

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

If you wish to complete an Advance Directive, copies of the official State forms are available at our facility.

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

DISCLOSURE OF OWNERSHIP

Northwest Georgia Orthopaedic Surgery Center is proud to have a number of quality physicians invested in our facility. Their investment enables them to have a voice in the administration of policies of our facility. This involvement helps to ensure the highest quality of surgical care for our patients. Your physician **does /does not** ***(circle as appropriate)*** have a financial interest in this facility.

By signing this document, I acknowledge that I have read and understand its contents:	
Patient/Patient Representative Signature	Date

MAK ANESTHESIA NW, LLC
1300 Ridenour Blvd
Suite 300
Kennesaw, GA 30152

Providing Professional Anesthesia Services for patients of
NORTHWEST GEORGIA ORTHOPAEDIC SURGERY CENTER

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to MAK Anesthesia, NW, LLC (Practice), all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of Practice charges for this admission or other amounts as may be provided by an agreement between the Practice and my insurance company). I authorize and direct the insurance company to pay all such benefits to the Practice. I understand that this assignment does not relieve me of any responsibility I may have for payment and charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and the Practice.

Authorization to Release Claim Information: I hereby authorize the Practice, its employees and agents, to release and disclose all information that has been and that will be received, recorded or compiled by and all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare) or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such persons. I hereby authorize the Practice, its employees and agents to act on my behalf in completing claims.

Precertification & Financial Responsibility: I understand that my insurer may require compliance with a utilization review (UR) program to ensure that plan benefits are justified. I understand that it is the insurer's UR program's responsibility to review proposed elective admissions and anticipated courses of treatment. I understand that if the UR program determines that the admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, healthcare benefits may be withheld. I understand that the Practice is willing to provided professional Anesthesia services as requested by my attending physician. I also understand that I may be financially responsible for all related charges incurred as a result of this admission should the UR review program refuse to certify that the admission or specific service was appropriate, or should the certification effort occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company, UR program, and personal physician without delay and in advance of my admission.

_____ _____

Signature of Patient/Authorized Guardian Signature **Date**

PATIENT NOTICE REGARDING ANESTHESIA SERVICES

ANESTHESIA SERVICES ARE PROVIDED AT NORTHWEST GEORGIA ORTHOPAEDIC SURGERY CENTER BY PRACTICE, AND ITS EMPLOYEES ARE INDEPENDENT HEALTH PROVIDERS AND ARE NOT EMPLOYEES OR AGENTS FOR NORTHWEST GEORGIA ORTHOPAEDIC SURGERY CENTER. PRACTICE EMPLOYEES CERTIFIED REGISTERED NURSE ANESTHETISTS AND PHYSICIAN ASSISTANT ANESTHESIOLOGY ASSISTANTS AS PART OF THE ANESTHESIA CARE TEAM.

ANESTHESIA SERVICES WILL BE BILLED SEPARATELY FROM THE SERVICES OF NORTHWEST GEORGIA ORTHOPAEDIC SURGERY CENTER.

FOR AN ESTIMATE OF ANESTHESIA CHARGES, OR OTHER BILLING QUESTIONS, CALL **(770) 702-1806.**

MAK Anesthesia NW, LLC is a wholly-owned subsidiary of MAK Anesthesia, LLC.

Northwest Georgia Orthopaedic Surgery Center
Patient Medication Reconciliation Form

Please list ALL prescriptions, over-the-counter, vitamins, topicals, and herbal/natural medications that are taken routinely.

Medication	Dose	How Often	Date and Time of Last Dose To Be Filled out by the Nursing Staff		
e.g. Aspirin	e.g. 81mg	e.g. one/day	Visit 1	Visit 2	Visit 3

DRUG ALLERGIES/REACTION

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Originally Recorded by RN/Date/Time _____

Patient Signature if Original DOS _____

Updated by RN/Date/Time _____ Pt _____

Updated by RN/Date/Time _____ Pt _____

Updated by RN/Date/Time _____ Pt _____

Prescriptions Given to Patient Upon Discharge

Medication	Dose	Frequency	Date Received	Rx Given in MD office prior to surgery

* Resume pre-op medications as listed above per PCP/Specialist unless otherwise instructed.

Comments: _____

Discharge RN Signature/Date/Time	Physician Signature/Date/Time

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # _____

Work # _____

Mobile # _____

Other _____

E-Mail Communication Preferences

Email Address_____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Northwest Georgia Orthopaedic Surgery Center, its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, Northwest Georgia Orthopaedic Surgery Center, its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update Northwest Georgia Orthopaedic Surgery Center when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

_____

Patient's Signature for consent to text message.

Mail Communication Preferences

May we send mail to your home address? (**If no, please provide an alternate mailing address below.**)

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information and/or financial information? (Check all that apply)

	Name:	Telephone
☐ Spouse	_____	_____
☐ Caretaker	_____	_____
☐ Child	_____	_____
☐ Parent	_____	_____
☐ Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**