YUMA ADVANCED SURGICAL SUITES, LLC

PATIENT'S RIGHTS AND RESPONSIBILITIES

A. PATIENT RIGHTS

- Every patient has the right to be informed of his/her rights in a manner he/she can understand and to exercise these rights without being subjected to discrimination or reprisal.
- Every patient has the right to courtesy, respect, dignity, privacy responsiveness, and timely attention to his/her needs regardless of age, race, sex, national origin, religion, cultural, or physical handicap, personal values, preferences, and beliefs.
- Every Patient has the right and need for effective communication.
- Every patient has the right to every consideration of his privacy and individuality as it relates to his social, religious and psychological wellbeing.
- Every patient has the right to confidentiality. Has the right to approve or refuse the release of medical information to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third-party payment contract.
- Every patient has the right to express grievances or complaints without fear of reprisals.
- Every patient has the right to a safe environment.
- Every patient has the right to continuity of health care. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements.
- Every patient is provided complete information regarding diagnosis, treatment and prognosis, as well as alternative treatments or procedures and the possible risks and side effects associated with treatment. If medically inadvisable to disclose to the patient such information, the information is given to a person designated by the patient or to a legally authorize individual.
- Every patient has the right to be free from any act of discrimination or reprisal.
- Every patient has the right to make decisions regarding the health care that is recommended by the physician, accordingly, the patient may accept or refuse any recommended medical treatment and must be informed of the consequences of his/her actions.
- Every patient has the right to be informed of any research or experimental projects and to refuse participation without compromise to the patient's usual care.
- Every patient has the right to appropriate treatment and care to include the assessment/managements of pain.
- Every patient has the right to and explanation and to understand facility charges related to your health care.
- Every patient has the right to all resuscitative measures: therefore, we will not honor Advance Directives.
- Every patient has the right to be free from all forms of abuse or harassment.
- Every patient has the right to personal privacy.
- Every patient has the right to change providers if other qualified providers are available.

B. PATIENT RESPONSIBILITIES

- Patients are responsible to be honest and direct about matters that relate to them, including answering questions honestly and completely.
- Patients are responsible to provide complete and accurate past and present medical history, present complaints, past illnesses, hospitalizations, surgeries, existence of advance directive, any medications taken, including over the counter products and dietary supplements, any allergies or sensitivities, and other pertinent data to the best of their ability.
- Patients are responsible to follow the treatment plan prescribed by his/her provider and participate in his/her care. Agree to accept all care givers without regard to race, color, religion, sex, age, gender preference or handicap, or national origin.
- Patients are responsible for assuring that the financial obligations for health care rendered are paid in a timely manner.
- Patients are responsible to sign required consents and releases as needed.
- Patients are responsible for their actions if they should refuse a treatment or procedure, or if they don't follow up or understand the instructions given them by the physician or Surgery Center employees.
- Patients are responsible for keeping their procedure appointment, if they anticipate a delay or must cancel, they will notify the Surgery Center as soon as possible.
- Patients are responsible for the disposition of their valuables, as the Surgery Center does not assume the responsibility.

- Patients are responsible to be respectful of others, other people's property, and the property of the Surgery Center.
- Patients are to observe safety and no smoking regulations.
- Patients are responsible for providing a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by the provider.

PATIENT COMPLAINT OR GRIEVANCE:

To report a complaint or grievance, you may contact the facility Administrator by phone, at 928-259-7522 or by mail to our address. Complaints and grievances may also be filed through: **The Arizona Department of Health Services**, in writing at: 150 N. 18th Avenue, Phoenix, AZ 85007, OR by phone at 602-542-1025, or fax at 602-542-0883.

Patient safety concerns can be reported to **The Joint Commission** at www.jointcommision.org, using the "Report a Patient Safety Event" link in the "Action Center" on the home page of the website, by fax to 630-792-5636, by mail to Office of Quality and Patient Safety, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181

All Medicare beneficiaries may file a complaint or grievance with The Medicare Beneficiary Ombudsman on-line at: **www.medicare.gov/ombudsman/resources.asp**

I understand my rights and responsibilities as a patient of Yuma Advanced Surgical Suites.

_____ _____

Signature of patient, responsible party, or surrogate Date

_____ _____

Witness Date

NOTICE OF PRIVACY PRACTICE

Insurance Portability and Accountability Act of 1996 (HIPAA) Effective April 14, 2003

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.

YUMA ADVANCED SURGICAL SUITES, LLC is required by law to maintain the privacy of your health information to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at YUMA ADVANCED SURGICAL SUITES, LLC please see the contact information at the end of this document.

I. **HOW YASS MAY USE OR DISCLOSE YOUR HEALTH INFORMATION**

YASS collects and protects the privacy of your health information. The law permits YUMA ADVANCED SURGICAL SUITES, LLC. to use or disclose your health information for the following purposes:

1. TREATMENT: YUMA ADVANCED SURGICAL SUITES, LLC may use your health information to provide you with medical treatment or services. For example, information obtained from you by a front office personnel or nurse is necessary to determine what treatment you should receive.
2. PAYMENT: YUMA ADVANCED SURGICAL SUITES, LLC may use and disclose health information about you for payment for treatment and services you receive. For example, your health information may be sent to a third party payer such as an insurance company or health plan in order for YASS to receive payment for services rendered.
3. HEALTHCARE OPERATIONS: YUMA ADVANCED SURGICAL SUITES, LLC may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to evaluate the performance of our staff; assess the quality of care and outcomes in your case and similar cases; and to determine how to continually improve the quality and effectiveness of the health care we provide.
4. INFORMATION PROVIDED TO YOU AND ON YOUR AUTHORIZATION: You may give YUMA ADVANCED SURGICAL SUITES, LLC written authorization to use or disclose your health information.
5. NOTIFICATION AND COMMUNICATION WITH FAMILY: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. REQUIRED BY LAW: As required by law, YASS may use and disclose your health information. For example, YUMA ADVANCED SURGICAL SUITES, LLC may disclose health information for the following reasons; judicial and administrative proceedings, to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes; to the Department of Health and Human Services to determine if we are in compliance with federal laws; or to appropriate persons in order to prevent or lessen a serious and imminent threat to the public or safety of a particular person or the general public.
7. PUBLIC HEALTH: As required by law, YUMA ADVANCED SURGICAL SUITES, LLC may use and disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; to aid with disaster relief, and reporting disease or infection exposure.
8. HEALTH OVERSIGHT ACTIVITIES: YUMA ADVANCED SURGICAL SUITES, LLC may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure, and other proceedings.
9. DECEASED PERSON INFORMATION AND ORGAN DONATIONS: YUMA ADVANCED SURGICAL SUITES, LLC may disclose your health information to coroners, medical examiners, funeral directors, or to organizations involved in procuring, banking or transplanting organs and tissues.
10. RESEARCH: YUMA ADVANCED SURGICAL SUITES, LLC may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.
11. WORKER'S COMPENSATION: YUMA ADVANCED SURGICAL SUITES, LLC may disclose your health information as necessary to comply with worker's compensation laws.

12. MARKETING: YUMA ADVANCED SURGICAL SUITES, LLC may contact you to give you information about treatments or health –related benefits and services that may be of interest to you.
13. GOVERNMENT FUNCTIONS: Specialized government functions such as protection of public officials or reporting to various branches of the armed services may require use or disclosure of your health information.
14. APPOINTMENTS: YUMA ADVANCED SURGICAL SUITES, LLC may use your information to provide appointment reminders by telephone, email or postal service.
15. BUSINESS ASSCOCIATES: We work with other businesses to help YUMA ADVANCED SURGICAL SUITES, LLC operate successfully. We may disclose your health information to these business associates so that they can perform the tasks we hired them to do. Our business associates must guarantee us that they will respect the confidentially of your personal health information.

II. WHEN YASS MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATON.

Except as described in the Notice of Privacy Practices, YUMA ADVANCED SURGICAL SUITES, LLC will not use or disclose your health information without your written authorization.

III. YOUR HEALTH INFORMATION

1. You have the right to request restrictions on certain uses and disclosures of your health information. YUMA ADVANCED SURGICAL SUITES, LLC is not required to agree to the restrictions that you request.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location. Request must be made in writing detailing the alternative methods chosen and could be applicable to fees.
3. You have the right to inspect and/or obtain a copy of your health information for a reasonable fee.
4. You have the right to request that YASS amend your health information that is incorrect or incomplete. YUMA ADVANCED SURGICAL SUITES, LLC is not required to change your health information and will provide you information about the denial process.
5. You have the right to receive and accounting or disclosure of your health information made by YUMA ADVANCED SURGICAL SUITES, LLC except that YUMA ADVANCED SURGICAL SUITES, LLC does not have to account for the disclosure described in treatment, payment, healthcare operation, and government functions of section I of this notice. The first accounting of disclosers within a twelve-month period is free. Any additional accountings in that time frame are subject to a fee.
6. You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
7. You have a right to obtain a paper copy of this notice upon arrival.
8. You have the right to be notified in the event of a breach in YASS's patient information.
9. You have the right to request that your health plan not be informed of your treatment at YUMA ADVANCED SURGICAL SUITES, LLC if you pay in full and your insurance company is not billed.

IV. **CHANGES TO THIS NOTICE OF PRIVACY PRACTICES**

YASS reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, YUMA ADVANCED SURGICAL SUITES, LLC is required by law to comply with this notice. A paper copy of this notice is available if you request a copy.

V. **COMPLAINTS**

If you believe that your privacy rights have been violated or if you have complaints about this Notice of Privacy Practices, contact:

YUMA ADVANCED SURGICAL SUITES
1030 W. 24th Street Suite H.
Yuma AZ, 85364
PHONE: (928) 259-7522 **FAX**: (928)259-7548

If you are not satisfied with the manner in which YUMA ADVANCED SURGICAL SUITES, LLC handles a complaint, you may submit a formal written complaint to the Department of Health and Human Services, Office for Civil Rights. You will not be retaliated against for filing a complaint.

_____ _____

Patient/Representative Signature Date

YUMA ADVANCED SURGICAL SUITES, LLC

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS, & DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to Yuma Advanced Surgical Suites, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, under any policy of insurance or other health care coverage in which the patient is a covered beneficiary, otherwise payable to me for services, treatments, therapies, including major medical, rendered or provided by the above-named health care provider, including their professional corporations or business entities, including without limitation, if applicable, pathology provider, anesthesia provider, and radiology provider by reason of this admission, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, including major medical, provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chosen action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Medicare: The undersigned parties do hereby assign, transfer and set over any and all Medicare benefits payable for health services relating to this admission to the above-named health care provider, including their professional corporations or business entities, including but not limited to, if applicable, pathology provider, anesthesia provider, and radiology provider, and hereby authorize said healthcare providers or their corporations to submit claims directly to Medicare for payment on behalf of the undersigned patient. Items not covered by Medicare will be the responsibility of the undersigned financially responsible party.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original. **THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.**

_____

NAME OF PATIENT

_____ _____

SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE & RELATIONSHIP DATE
FINANCIALLY RESPONSIBLE PARTY

_____ _____

WITNESS DATE

AUTHORIZATIONS & DISCLOSURES

These AUTHORIZATIONS & DISCLOSURES MUST BE SIGNED BY THE PATIENT, or by the party legally and financially responsible for a minor or physically or mentally incapacitated patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize any anesthesia, medical or surgical treatment, including services rendered or provided under the general and special instructions of my attending physician, his/her assistants, and other practitioners associated, as may, in their professional judgment be deemed necessary or beneficial for the purposes of diagnosis, treatment and medical care at Yuma Advanced Surgical Suites. NO PROMISE, GUARANTEE OR WARRANTY HAS BEEN MADE REGARDING THE RESULTS OF ANY MEDICAL TREATMENT OR SURGICAL PROCEDURE. Any and all removed organs, or parts may be disposed of in accordance with accepted medical practices.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR REIMBURSEMENT: For purpose of reimbursement, Yuma Advanced Surgical Suites, and each attending or treating practitioner, including, but not limited to, pathology, anesthesia, radiology and laboratory providers, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my employer, insurance companies, other organizations, third party payors, or agencies as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement. I understand that such disclosures may contain information which could result in limitation or denial of insurance benefits or third-party reimbursement or which could otherwise be harmful or prejudicial to my interests.

AUTHORIZATION TO RELEASE MEDICAL AND PAYMENT INFORMATION TO SPECIFIC INDIVIDUALS: Yuma Advanced Surgical Suites, and each attending or treating practitioner are hereby authorized and directed, during my period of this admission, to disclose medical and payment information to my spouse, children, parents, and any other person authorized to consent to treatment pursuant to current state law, concerning my health status, diagnosis, prognosis, and progress.

Yuma Advanced Surgical Suites, is also hereby authorized and directed to disclose and discuss matters related to billing and payment after the period of admission. I do hereby release and hold Yuma Advanced Surgical Suites, its officers, directors, agents, employees, and all examining and treating practitioners harmless of and from any and all costs, loss damage, or liability resulting from or arising out of such disclosures.

I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care to whom medical and payment information may be released:

_____

_____ Please do not release my medical or payment information to any individuals.

RELEASE OF RESPONSIBILITY FOR VALUABLES: Yuma Advanced Surgical Suites, is hereby fully released of and from any and all responsibility for loss or damage to my personal property, money, or valuables.

NOTICE OF PRIVACY PRACTICES: I am aware of my rights to privacy of personal health information, under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and am aware that a copy of these rights is available to me upon request.

RIGHTS AND RESPONSIBILITIES: I acknowledge that I have received, prior to my procedure, a copy of the Patient Rights and Responsibilities, which includes information regarding where and how I can file a grievance or complaint.

PHYSICIAN OWNERSHIP DISCLOSURE: Yuma Advanced Surgical Suites, provides services only to patients admitted by private practitioners who are members of the Medical Staff, some of whom retain joint ownership of the surgery center. I understand I may choose another facility for the services I require, and have elected to receive care at Yuma Advanced Surgical Suites.

TRANSPORTATION RELEASE: I understand that the anesthetic to be administered to me may have effects that make it hazardous

for me to drive a car or otherwise travel alone to my home following my procedure and discharge. I have arranged for transportation with a responsible adult to my home and will be under the supervision of a responsible adult for 24 hours following my procedure. I understand that Yuma Advanced Surgical Suites, will not perform my schedule procedure unless these arrangements are met, and have provided Yuma Advanced Surgical Suites, with my designated responsible party's name and phone number. The responsible party agrees to assume responsibility for accompanying and transporting the named patient to his/her home.

_____ Responsible Party initials

_____		_____
Responsible Party Name	Relationship	Phone Number

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I have received information about the Advanced Directives Policy at Yuma Advanced Surgical Suites, and I understand that the center policy (regardless of the contents of any advance directive or instructions from a health care surrogate attorney in fact) is to initiate resuscitative measures, should an adverse event occur during my procedure. I would be transferred to the closest acute care facility for further evaluation, where further treatment or withdrawal of treatment measures already begun will be ordered in accordance with my wishes, advance directive or health care power of attorney. My agreement with this policy does not revoke or invalidate any current health care directive or health care power of attorney. Please check one of the following:

- ○ YES, I brought my Advanced Directive/Living Will/Health Care Proxy with me to place a copy in my chart as part of my medical record
- ○ YES, I have an Advanced Directive/Living Will/Health Care Proxy, but did not bring it with me
- ○ NO, I do not have an Advanced Directive/Living Will/Health Care Proxy
- ○ I wish to have information on how I can obtain an Advanced Directive/Living Will/Health Care Proxy

NOTICE OF FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to Yuma Advanced Surgical Suites, for any and all charges associated with the services rendered by Yuma Advanced Surgical Suites, whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. Yuma Advanced Surgical Suites, verifies insurance benefits, however exact coverage and benefits cannot be determined until the claim is received and reviewed by my insurance carrier. I understand this is not a guarantee of payment from an insurance carrier, and all benefits are subject to the conditions and limitations of the plan and are subject to change. I understand that I am financially responsible for charges not covered by an assignment of benefits, or for charges which the insurance carrier declines to pay. When a health plan denies some or all of the charges, Yuma Advanced Surgical Suites, will pursue the internal appeals provided by the health plan, and will only bill the patient for any amounts which remain outstanding after the appeals are exhausted. I further acknowledge:

1. Yuma Advanced Surgical Suites, may be a non-participating provider with my insurance plan, the status of which I have been informed of, and I have chosen to obtain services at this facility.
2. Yuma Advanced Surgical Suites, bills both patients and health plans using the same fee schedule, and my financial obligation is based on my applicable benefit levels associated with services for which Yuma Advanced Surgical Suites, will bill my health plan pursuant to an assignment.
3. Where contractual rates do not apply, patients and health plans are offered discounts based on the time of payment, in accordance with the Yuma Advanced Surgical Suites, Financial Policies, a copy of which is available to me upon request, and has also been made available to my health plan.
4. I am aware of my right to request a complete written estimate of the anticipated charges, and my associated financial responsibility. I understand that the fee quoted to me for the surgery facility is an ESTIMATE only, and it is possible that I will receive a bill for any balance which I remain financially obligated to pay.

5. Fees for anesthesia services, physician fees, pathology services, laboratory fees, durable medical equipment and surgical assistants, or other services rendered which are not included in the facility global rate will be billed separately where applicable.
6. When a payment is received by the patient, directly from the health plan they have assigned to Yuma Advanced Surgical Suites, patient must endorse and forward the payment and Explanation of Benefits to Yuma Advanced Surgical Suites, as soon as the payment is received to avoid additional financial liability.

MEDICARE CERTIFICATION AND AUTHORIZATION: Each of the undersigned certifies that the information given in applying for payment under Title XVII of the Social Security Act, if applicable, is correct. Any holder of medical or other information about the patient pertaining to this admission, is authorized by the Social Security Administration as applicable, or their intermediaries or carriers, any information needed for any Medicare claim and to request that payment of authorized benefits be made on the patient's behalf. The Medicare program is authorized to furnish medical or other information needed for any Medicare claim and to request that payment of authorized benefits be made under Title XVII as necessary to process any complimentary coverage claim.

THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.

_____ _____

NAME OF PATIENT DATE

_____ _____

NAME OF AUTHORIZED REPRESENTATIVE & FINANCIALLY RESPONSIBLE PARTY DATE

_____ _____

SIGNARTURE OF PATIENT DATE

_____ _____

WITNESS DATE

YUMA ADVANCED SURGICAL SUITES, LLC

TRANSPORTATION RELEASE

I understand that the anesthetic to be administered to me may have effects that may make it hazardous for me to drive a car or to otherwise travel alone to my home following the recovery period. I do understand that Yuma Advanced Surgical Suites, LLC will not perform my scheduled surgical procedure unless I have arranged a responsible adult to accompany me and transport me to my home.

I have been advised to have someone with me at home for the first 24 hours of my surgery. I also understand that I will not be discharged until the responsible adult transporting me home has signed this form prior to the discharge.

Patient Label

I hereby assume responsibility for accompanying and transporting the above-named patient to his/her her home.

_____ _____

Signature of responsible adult/Transporter Phone Number

_____

Relationship

_____ _____

Witness Date

Revised 9/9/2020