

## PATIENT'S RIGHTS & RESPONSIBILITIES

### RIGHTS

- Every patient has the right to *courtesy, respect, dignity, privacy, responsiveness, and timely attention* to his/her needs regardless of age, race, sex, nationality, origin, religion, cultural, or physical handicap, personal value and beliefs.
- Every patient has the right to every consideration of his *privacy and individuality* as it relates to his social, religious and psychological well-being.
- Every patient has the right to *confidentiality*. The patient 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 *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 authorized individual.
- 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.
- 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 understand facility charges. You have the right to an explanation of all facility charges related to your health care.
- Every patient has the right to all resuscitative measure; therefore, we will not honor Advance Directives.

### 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 accurate* past and present *medical history*, present complaints, past illnesses, hospitalizations, surgeries, existence of advance directive, medication and other pertinent data.
- *Agree to accept all caregivers 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 do not follow or understand the instructions given to them by the physician or Maryland Specialty Surgery Center, LLC employees.
- Patients are responsible for *keeping their procedure appointment*. If they anticipate a delay or must cancel, they will notify the Maryland Specialty Surgery Center, LLC as soon as possible.
- Patients are responsible for the *disposition of their valuables*, as they Maryland Specialty Surgery Center, LLC does not assume the responsibility.
- Patients are responsible to be *respectful of others, or other people's property* and the property of the Maryland Specialty Surgery Center, LLC.
- Patients are to *observe safety and no smoking regulations*.

#### **PATIENT COMPLAINT OR GRIEVANCE:**

To report a complaint or grievance, you may contact the facility Administrator by phone at 410-589-6340 or by mail to our address.

Complaints and grievances may also be filed through the Maryland Department of Health & Mental Hygiene, Office of Health Care Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Ave., Catonsville, MD 21228, or by phone at 1-800-492-6005.

All Medicare beneficiaries may file a complaint or grievance with the Medicare Beneficiary Ombudsman online at: [www.medicare.gov/ombudsman/resources.asp](http://www.medicare.gov/ombudsman/resources.asp).



## ADVANCE DIRECTIVE ACKNOWLEDGEMENT

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 communicate decisions. This surgery center respects and upholds those rights.

However, unlike in an acute care hospital setting, the surgery center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without 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 attorney in fact, that if an adverse event occurs during your treatment at this facility we will initiate resuscitating or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatment 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 policy does 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.

Yes, I do have an Advance Directive

No, I do not have an Advance Directive

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date



## AUTHORIZATIONS & DISCLOSURES

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

**AUTHORIZATION FOR MEDICAL TREATMENT:** The undersigned hereby authorizes 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 Maryland Specialty Surgery Center, LLC. 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 purpose of reimbursement, Maryland Specialty Surgery Center 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. Unless specifically instructed otherwise, Maryland Specialty Surgery Center, LLC and each attending or treating practitioner are hereby authorized and directed, during the period of this admission, to disclose information to the patient's spouse, children, parents, and any other person authorized to consent to treatment pursuant to 431.061-.065, RSMO (1979) as amended, concerning the patient's health status, diagnosis, prognosis, and progress. Each of the undersigned do hereby release and hold Maryland Specialty Surgery Center, LLC, 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.

**RELEASE OF RESPONSIBILITY FOR VALUABLES:** Maryland Specialty Surgery Center, LLC is hereby fully released of and from any and all responsibility for loss or damage to the personal property, money or valuables of the undersigned patient.

**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 are 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:** Maryland Specialty Surgery Center, LLC 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 Maryland Specialty Surgery Center, LLC.

**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 Maryland Specialty Surgery Center, LLC will not perform my scheduled procedure unless these arrangements are met, and have provided Maryland Specialty Surgery Center, LLC 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.

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Responsible Party Name

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Signature

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Phone Number

**NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES:** I have received information about the Advanced Directives Policy at Maryland Specialty Surgery Center, LLC 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 Maryland Specialty Surgery Center, LLC for any and all charges associated with the services rendered by Maryland Specialty Surgery Center, LLC whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. Maryland Specialty Surgery Center, LLC 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, Maryland Specialty Surgery Center, LLC 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. Maryland Specialty Surgery Center, LLC 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. Maryland Specialty Surgery Center, LLC 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 Maryland Specialty Surgery Center, LLC will bill my health plan pursuant to an assignment.
3. Where contractual rates do not apply, tiered prompt pay discounts off the estimated charges are offered equally to health plans and patients, in accordance with the Maryland Specialty Surgery Center, LLC Financial Policies, a copy of which is available to me upon request.
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 Maryland Specialty Surgery Center, LLC, patient must endorse and forward the payment and Explanation of Benefits to Maryland Specialty Surgery Center, LLC 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.

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NAME OF PATIENT

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SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE &  
FINANCIALLY RESPONSIBLE PARTY

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RELATIONSHIP

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DATE

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WITNESS

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DATE



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

I hereby assign and convey directly to the above-named health care provider, 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 feisor 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.

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NAME OF PATIENT

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SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE &  
FINANCIALLY RESPONSIBLE PARTY

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

PATIENT LABEL HERE