

CONDITION OF ADMISSION

I understand that I am scheduled to go home after my procedure, and I must have a responsible adult drive me home and stay with me as advised.

- I understand state law allows that in the event a healthcare worker is exposed to my blood or body fluids during my admission, my blood shall be tested at no cost to me, using a special coded system to ensure confidentiality, for the HIV antibody and other communicable diseases. If such exposure occurs, I will receive additional information about such tests. I understand that the results of such tests do not become a part of my medical record.
- I understand and agree that the center shall not be liable for loss or damage to any personal property, including but not limited to money, jewelry, glasses, dentures, or hearing aids. I have been advised not to bring valuables or any unnecessary articles.
- I authorize the taking of still photographs under fluoroscopy or motion pictures or video or closed-circuit television during the procedure. These photos will only be used for treatment unless they are (1) de-identified, or (2) a HIPAA-compliant authorization is signed.
- I approve the disposal of any tissue or parts that may be removed in accordance with customary practice.
- I authorize the presence of an observer during my procedure when PSA Surgery Center of Killeen healthcare provider determines such is necessary for the purpose of rendering technical advisory assistance to the healthcare provider, for educational purposes, or to support the patient.
- I understand that I am expected to disclose any indication of having been exposed to COVID-19, or whether I have experienced any signs of symptoms associated or diagnosed with COVID-19 virus. I understand and accept the additional risk of contracting Covid-19 from contact at this office. I acknowledge that I could contract COVID-19 virus outside of this office in circumstances unrelated to my visit here.
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ADVANCE DIRECTIVE NOTIFICATION

In the State of Texas, all patients have the right to participate in their own healthcare 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. PSA Surgery Center of Killeen respects and upholds those rights. However, unlike in an acute care hospital setting, PSA Surgery Center of Killeen does not routinely perform "high risk" procedures. While no surgery is without risk, most procedures performed in this facility are of minimal risk. You will discuss the specifics of your procedure with your healthcare provider 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 healthcare surrogate or attorney-in-fact, that if an adverse event occurs during 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 healthcare Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current healthcare directive or healthcare 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 or transferring your procedure to another facility.

The patient has a right to have an Advance Directive, such as a living will or health care proxy. These documents express the patient's choices about future care or name someone to decide if the patient cannot speak for himself or herself. The patient who has an Advance Directive must provide a copy to the facility and to their healthcare provider for their wishes to be made know and honored.

Do you have an advance directive? _____

OFFICE AND FINANCIAL POLICY

Thank you for choosing the PSA Surgery Center of Killeen. In order to inform you of our current Office and Financial Policy, please read the document below and sign the Financial Agreement. Our providers, clinical, and office staff are here to help you in any way possible and strive to make your experience with us pleasant and comforting. Keep a copy of this document for your records and should you have any questions please do not hesitate to ask one of our associates.

Please keep us informed of any address, telephone number, or name changes. If we are unable to contact you regarding your bill, we will refer the balance to our outside collection agency. Please notify our office within 24 hours to reschedule or cancel an appointment. This will allow our staff to offer this time slot to another patient in need of an appointment.

We accept the following forms of payment: debit card, credit cards, cashier's checks, money orders, and personal checks.

Returned Checks:

- Returned checks will accrue a \$50.00, as well as any applicable bank fees to your account.

Insurance

- It is your responsibility to know your level of benefits for services provided. Being that our providers are specialist, many services are required to have prior authorizations by the insurance company and/or Primary Care Provider. Please contact your insurance company before your appointment to ensure proper authorization and an estimate of payment due as we aren't certain what the patient balance will be until the insurance company processes your claim.
 - Payment of fees, co-pays, co-insurance and deductibles are due at the time of service.
 - Co-pays are a requirement placed on you by your insurance company and therefore cannot be waived or reduced. Should you forget or cannot provide your co-pay at the time of visit; you will be asked to reschedule your appointment.
 - You are solely responsible for your balance in the form of co-insurance, deductible, or non-covered services as required by your insurance company.
 - You will be contacted prior to your appointment and notified of any balance due on your account and will be expected to bring payment to your appointment. You will be required to make arrangements with the financial counselor if you cannot pay the balance in full.
 - Should any balance remain unpaid more than 90 days past the processing date with the insurance company, a statement will be sent to the guarantor of the account and payment will be due upon receipt of the statement.
- #### **Worker's Compensation**
- Please keep in contact with your adjuster prior to and after your appointment to receive any pertinent information regarding your claim and injury.
 - Authorizations may be required for certain procedures and could take up to 1 week to obtain.
 - Should your case become closed, undergo peer review, or determined that Maximum Medical improvement has been met you must contact your referring provider and adjuster for written approval before scheduling any appointment or services.

FINANCIAL AGREEMENT

I have read and understand the financial policy and agree to its terms. I understand that insurance billing is a courtesy provided to me by the PSA Surgery Center of Killeen and I assume full financial responsibility of the balance I incur. I understand co-pays, co-insurance, and deductibles are due at the time of my visit as well as any prior balance I may owe.

I assign benefit to be paid by my insurance company directly to the provider of services rendered to me. Furthermore, should the insurance company issue a check in my name I will notify PSA Surgery Center of Killeen immediately and arrange for payment of my balance. Should I cash any check issued by the insurance company meant for reimbursement of services provided to me, I will assume full responsibility of the balance and will pay the balance within 30 days.

I understand my balance will automatically be referred to an outside collection agency should my account surpass 90 days without payment activity. I agree to pay all reasonable attorneys, collection, or returned check fees in the event of default of payment of my charges or balance arrangements.

I understand that the fees quoted to me for my procedure and any payments made the day of my procedure are for the surgery center only. A statement and bill for the professional fees will be sent separately.

I understand that if I opt for anesthesia services provided by MedStar Anesthesia, for my procedure, I will be responsible for all co-pays, co-insurances, and deductibles. I have been informed that this service is billed as out of network with my insurance company.

Notice of Physician Ownership. I understand that Drs. Mehta, and Fronk has a financial interest in the PSA Surgery Center of Killeen. I am not required to use the PSA Surgery Center of Killeen and have the right to choose another facility of my choice. I will not be treated differently by my physician if I choose to use another facility. I acknowledge that I understand this notice of physician ownership, I received it prior to the start of my procedure, and I chose to have my procedure at PSA Surgery Center of Killeen.

THE HIPAA NOTICE OF PRIVACY PRACTICE

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.

Information about you and your health is personal, and we are committed to protecting your privacy. This notice tells you about our privacy practices, the ways in which we may use and share your health information, and how you can get access to your health information. This notice also describes your rights and our responsibilities regarding the use and disclosure of health information.

Our Uses and Disclosures

We typically use and share your health information in the following ways:

Treat you: We can use your health information and share it with other professionals who are treating you. Examples: we will share health information about you with an ambulatory surgical center where you are scheduled for a procedure; we will share your health information with a healthcare provider to whom you have been referred for further treatment.

Bill for our services: We can use and share your health information to bill and receive payment from health plans and other entities. Example: we will share your health information with your health insurance plan so it will pay for services we provide to you.

Run our organization: We can use and share your health information to run our operations, train medical students, improve your care and contact you when necessary. Examples: we may call you by name in the waiting room when your physician is ready to see you; we may use your health information in our quality improvement reviews.

We can also de-identify your health information and use and disclose such de-identified information for any purpose.

Communicate regarding treatment alternatives or appointment reminders: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related services that may be of interest to you.

How else can we use or share your health information? We are allowed or required to share your health information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information, see: <https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html>.

Help with public health and safety issues: We can share information about you for certain situations, such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Food and Drug Administration (FDA): We may share health information with the FDA relative to adverse events with respect to food, medications, devices, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' comp, law enforcement & other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

To ensure PSA ASC Killeen patients are aware of their rights and responsibilities, the rights and responsibilities are posted in a prominent place and/or provided in pamphlet form for patient review.

PATIENT RIGHTS

- I. Each patient treated at PSA ASC Killeen has the right to:
 - A. Be treated with respect, consideration and dignity.
 - B. Respectful care given by competent personnel with consideration of their privacy concerning their medical care.
 - C. Receive care in a safe setting and free from all forms of abuse or harassment.
 - D. Be given the name of their attending physician, the names of all other healthcare providers directly assisting in their care, and the names and functions of other health care persons having direct contact with the patient.
 - E. Be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
 - F. Have records pertaining to their medical care treated as confidential and, except where authorized by law, patient shall be given the opportunity to approve or refuse their release.
 - G. Know what ASC rules and regulations apply to their conduct as a patient.
 - H. Expect emergency procedures to be implemented without necessary delay.
 - I. Be informed of the ASC's Policy on Advanced Directives.
 - J. Absence of clinically unnecessary diagnostic or therapeutic procedures.
 - K. Expedient and professional transfer to another facility when medically necessary and to have the responsible person and the facility that the patient is transferred to notified prior to transfer.
 - L. Treatment that is consistent with clinical impression or working diagnosis.
 - M. Good quality care and high professional standards which are continually maintained and reviewed. An increased likelihood of desired health outcomes.
 - N. Full information in non-technical language concerning appropriate and timely diagnosis, treatment, prognosis and preventive measures; if it is not medically advisable to provide this information to the patient, the information should be given to the responsible person on his/her behalf.
 - O. Receive a second opinion concerning the proposed surgical procedure, if requested.
 - P. Accessible and available health services; information on after-hour and emergency care.
 - Q. Give an informed consent to the physician prior to the start of a procedure.
 - R. Be advised of participation in a medical care research program or donor program; the patient should give consent prior to participation in such a program; a patient may also refuse to continue in a program that has previously given informed consent to participate in.
 - S. Receive appropriate and timely follow-up information of abnormal findings and tests.
 - T. Receive appropriate and timely referrals and consultation.
 - U. Receive information regarding "continuity of care".
 - V. Refuse drugs or procedures and have a physician explain the medical consequences of the drugs or procedures.
 - W. Appropriate specialty consultative services made available by prior arrangement.
 - X. Medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability, or source of payment.
 - Y. Have access to an interpreter whenever possible.
 - Z. Be provided with, upon written request, access to all information contained in their medical record.
 - AA. Accurate information regarding the competence and capabilities of the organization.
 - BB. Receive information regarding methods of expressing suggestions or grievances to the organization.
 - CC. Appropriate information regarding the absence of malpractice insurance coverage.
 - DD. Change primary or specialty physicians if other qualified physicians are available.
 - EE. Health Services provided are consistent with current professional knowledge.
- II. Information regarding fees for services and payment policies.

PATIENT RESPONSIBILITIES

- I. Each patient treated at ASC has the responsibility to:
 - A. Provide full cooperation with regards to instructions given by his/her surgeon, anesthesiologist, and operative care (pre and post). Behave respectfully towards healthcare professionals, staff, patients, and family/friends.
 - B. Provide complete and accurate information to the best of his/her knowledge regarding health, medications, allergies, etc.
 - C. Provide ASC staff with all medical information that may have a direct effect on the provider at the ASC.
 - D. Provide ASC with all information regarding third-party insurance coverage.
 - E. Fulfill financial responsibility, for all services received, as determined by the patient's insurance carrier.
 - F. Follow the treatment plan given by his/her provider.
 - G. Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required.



PSA Surgery Center of Killeen

A Pain Specialists of America Affiliate

You may contact the following entities to express any concerns, complaints, or grievance you may have:

ASC: Alicia Gipson, MSN, RN, ASC Administrator Ph: (254) 415- 7673 ext. 2441 Email: agipson@psadocs.com	STATE: Texas Department of State Health Services P.O. Box 149347, Austin, TX 78714-9347 Compliance Hotline: 888-973-0022
FOR MEDICARE PATIENTS: Medicare Ombudsman: (800) MEDICARE Email: http://www.cms.hhs.gov/ombudsman/resources.asp	AAAHC: AAAHC Institute for Quality Improvement 5250 Old Orchard Road, Suite 250 Skokie, IL 60077 847-853-6060

The role of the Medicare Ombudsman is to help you receive information and understand your Medicare Options and apply your Medicare Rights for your protection.

I ACKNOWLEDGE AND I HAVE RECEIVED AND/OR READ THE FOLLOWING DOCUMENTS:



PSA Surgery Center of Killeen

A Pain Specialists of America Affiliate

Patients have the right to request a paper copy of the forms mentioned below.

- **Condition of Admission**
- **Advanced Directive Notification**
- **The HIPPA Notice of Privacy Practice**
- **Office and Financial Policy**
- **Financial Agreement**
- **Patient Bill of Rights and Responsibilities**

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required)

Signature: _____ Date & Time: _____

If Legally Authorized Representative, list relationship to Patient: _____

Witness Signature: _____ Date & Time: _____