SURGICAL CONSENT

Surgical Procedure: ____

Surgeon: ____

Physician's Confirmation of Informed Consent:

I certify that I have explained to the patient or surrogate their condition, the proposed operation or procedure, attendant risks and possible discomfort involved, options of other methods of treatment (including doing nothing), and the possibility of complications.

____ _____________________________

Physicians Signature Date

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING ADVANCED DIRECTIVES OR LIVING WILLS

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___ I HAVE provided SCSC with a copy of my advanced directive or living will.
___ I HAVE an advanced directive or living will.
___ I DO NOT HAVE an advanced directive or living will.

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☐ Yes ☐ No Have you been out of the country in the past 3 weeks?

MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGEMENT THAT: (1) I HAVE READ OR HAVE HAD READ TO ME THE SURGICAL CONSENT FOR TREATMENT (PAGES 2-6) AND I AGREE TO IT. (2) THE PROCEDURE(S) HAS BEEN ADEQUETELY EXPLAINED BY MY PHYSICIAN OR HIS APPOINTED SURROGATE. (3) I AUTHORIZE AND CONSENT TO THE PERFORMANCE OF THE PROCEDURE(S) AND ANY ADDITIONAL PROCEDURE(S) DEEMED ADVISABLE BY MY PHYSICIAN IN HIS/HER PROFESSIONAL JUDGMENT.

- I understand if I have a living will or advance directive it will not be honored at SCSC today.
- I have arranged for a responsible adult to be present at the center during my procedure.
- I understand that I MUST have a responsible adult to receive D/C instructions & drive me home if I am receiving anesthesia.
- I understand that I should have a responsible person care for me 24 hours after my procedure if I am to receive anesthesia.
- I am aware my surgeon may own an interest in St Charles Surgery Center.
- I further understand it is my right to choose any other outpatient facility for this surgery.
- I have been informed of my Rights & Responsibilities prior to today verbally & in writing.
- I (We) understand that no warranty or guarantee has been made as to result or cure.
- Any and all of my questions have been sufficiently answered for me.
- I authorize my insurance to pay St Charles Surgery Center the amount due for Medical Benefits.
- I request the payment of authorized Medicare benefits to be made on my behalf.
- I agree to forward any check received from my insurance company to the surgery center.
- I agree, upon request from SCSC, to forward any EOB received from my insurance company.
- I agree to pay St Charles Surgery Center all indebtedness not covered by insurance.
- I will be accountable for unpaid balances until I have provided SCSC all insurance checks.

____ _____________________________

Signature of Patient Date

____ _____________________________

Interpreter (if needed) Date

____ _____________________________

Witnessed Date

THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD
(PAGES 2-6 ARE ATTACHED TO THE PATIENTS MEDICAL RECORD)

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TO THE PATIENT: You have the right, as a patient, to be informed about my condition and the recommended surgical, medical, or diagnostic procedure to be used so that I may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm me; it is simply an effort to make me better informed so I may give or withhold my consent to the procedure.

1. I hereby authorize the physician/surgeon listed on page 1 and such assistants as may be selected by him/her and/or the surgery center to perform the above listed surgical procedure(s). The procedure(s) listed to be performed, the nature and purpose of those procedures, and the advantages and disadvantages, risks and possible complications as well as the alternatives have been explained to me by my physician. The physician has satisfactorily answered my questions.
2. My consent is given with the understanding that any operation or procedure involves risks and hazards. The more common risks include: infection, bleeding, nerve injury, blood clots, heart attack, stroke, allergic reaction, damage to teeth or bridgework, and pneumonia. These risks can be serious and possibly fatal.
3. I authorize and direct the physician/surgeon listed on page 1 to arrange for such additional services for me, as deemed necessary or advisable, including but not limited to the administration of anesthesia and the performance of services involving pathology.
4. I understand that should it become necessary for me to be hospitalized during my stay at St Charles Surgery Center, the decision as to the hospital I will be transferred to will be the decision of my physician and not the decision of the Surgery Center. I hereby release St. Charles Surgery Center from all responsibility for care rendered to me at another healthcare facility.
5. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been given by anyone as to the results that may be obtained by the proposed operation or procedure.
6. I authorize the physician or pathologist to use his or her discretion in the disposition of any tissue or body parts that are removed.
7. I have been informed both verbally and in writing, prior to today, of my patient rights & responsibilities, advanced directives and living wills, as well as physician ownership of St Charles Surgery Center.
8. I am aware that even though I may have a Living Will and/or Advanced Directive, that in the event of a life threatening emergency, it is the policy of St. Charles Surgery Center to perform any and all necessary emergency resuscitation procedures and transfer me to an acute care hospital, with a copy (if provided by me) of my living will and/or advanced directive.
9. I authorize all doctors, pharmacists, or other institutions rendering care and treatment to furnish the responsible parties and/or insurance companies with full information regarding treatment rendered.
10. I consent to have my blood tested, if my physician should deem it necessary, to determine whether or not I have the antibodies in my blood to hepatitis virus (HBV) and to the human immunodeficiency virus (HIV), which is the probable causative agent for AIDS. I understand withdrawing blood from my vein starts this test and a substance is then used to test the blood. I understand that the blood sample may be drawn prior to my surgery, during surgery or after the procedure is performed.

11. I consent to the photographing of the operation or procedure to be performed for medical, scientific, or educational purposes, providing that my identity is not revealed by the pictures or by descriptive texts accompanying them.

12. For the purpose of advancing medical education, I consent to the admittance of appropriate observers to the operation and/or procedure room.

13. I understand that my physician may be an owner of St Charles Surgery Center.

14. I release the facility from any responsibility for loss and/or damage to money, jewelry, or other valuables I brought into the facility.

15. I understand that if I am pregnant or if there is any possibility I may be pregnant, I must inform the facility immediately since the scheduled procedure could cause harm to my child or to myself.

16. I understand that in order to receive anesthesia services I cannot have eaten or taken fluids by mouth, chewed gum or hard candy since midnight last night (or 6 hours for clear liquids or 8 hours for solid food prior to the start of my procedure), except for a sip of water taken with medications as instructed by my physician.

17. I agree to forward any checks, Explanation of benefits, or other correspondence relating to services rendered to me at St Charles Surgery Center to the surgery center's business office. I also understand that I will be held entirely accountable for any outstanding or unpaid balances on my account until I have turned over any and all checks received from my insurance company. In the event your deductible is met and we over collected at the time of service a refund will be issued to you in 30 to 60 days from the time St Charles Surgery Center received an EOB.

18. I understand that I am responsible for the charges incurred. In the event that I fail to pay these charges, I will be responsible for reasonable collection costs and/or attorney fees associated with the cost of resolving my account.

19. I understand that in order to receive anesthesia services it is my responsibility to have arranged for a responsible adult to drive me home and it is recommended that they remain with me following the surgery. I acknowledge that I have been advised by facility personnel not to drive until any effects of medication have worn off, typically 24 hours following the administration of anesthetics.

NOTICE OF PRIVACY PRACTICE

This document defines your Privacy Rights at St Charles Surgery Center as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

EFFECTIVE APRIL 14, 2003, and updated to Omnibus Rule EFFECTIVE MARCH 26, 2013
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

St. Charles Surgery Center is required by law to maintain the privacy of your health information and 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 St. Charles Surgery Center, please see the contact information at the end of this document.

ST. CHARLES SURGERY CENTER MAY USE OR DISCLOSE YOUR HEALTH INFORMATION.

St Charles Surgery Center collects and protects the privacy of your health information. The law permits St Charles Surgery Center to use or disclose your health information for the following purposes:

1. **TREATMENT**: St Charles Surgery Center 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**: St Charles Surgery Center may use and disclose health information to others or purposes of receiving payment for treatment and services that 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 St Charles Surgery Center to receive payment for services rendered. You will be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under this new Omnibus Rule.
3. **HEALTH CARE OPERATIONS**: St Charles Surgery Center 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 other to: evaluate the performance of our staff; assess the quality of care and outcomes in your cases and similar cases; and to determine how to continually improve the quality and effectiveness of health care we provide.
4. **INFORMATION PROVIDED TO YOU AND ON YOUR AUTHORIZATION**: You may give us 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, we may use and disclose your health information. For example, St Charles Surgery Center may disclose health information for the following reasons: judicial and administrative proceedings; to a law enforcement official for purposes such as 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 appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety or a particular person or the general public.
7. **PUBLIC HEALTH**: As required by law, we may disclose your health information to public health authorities for purpose related: preventing or controlling disease, injury or disability; report 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**: We 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 DONATION**: We 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**: We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.
11. **WORKER'S COMPENSATION**: We may disclose your health information as necessary to comply with worker's compensation laws.
12. **MARKETING**: We may contact you to give 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 of reporting to various branches of the armed services that may require use or disclosure of your health information.
14. **APPOINTMENTS**: St Charles Surgery Center may use your information to provide appointment reminders by phone, email, or postal services.
15. **BUSINESS ASSOCIATES**: We work with other businesses to help St Charles Surgery Center 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 confidentiality of your personal health information.

Except as described in this Notice of Privacy Practices, St Charles Surgery Center will not use or disclose your health information without your written authorization.

YOUR HEALTH INFORMATION RIGHTS.

1. You have the right to request restrictions on retain uses and disclosures of your health information. St Charles Surgery Center is not required to agree to the restriction that you requested.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location. Requests 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 St Charles Surgery Center amend your health information that is incorrect or incomplete. St Charles Surgery Center is not required to change your health information and will provide you with information about the denial process.
5. You have a right to receive an accounting of disclosures of your health information made by St Charles Surgery Center does not have to account for the disclosures described in treatment, payment, health care operations, and government functions of section I of this Notice. The first accounting of disclosures 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 the right to obtain a paper copy of the Notice upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES.

St Charles Surgery Center reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, St Charles Surgery Center is required by law to comply with the Notice. A paper copy of the Notice is available if you request a copy.

COMPLAINTS

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

St Charles Surgery Center
3501 Harry S Truman Blvd
St Charles, MO 63301
636-757-1973
Tabitha Vaughn, R.N.
Administrator & Clinical Director

If you are not satisfied with the manner in which St Charles Surgery Center 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.

Complaints Contact:
Office of Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201
877-696-6775

MEDICARE SERVICES CONDITIONS OF COVERAGE NOTIFICATION

In accordance with Medicare's Condition of Coverage for Ambulatory Surgical Centers, the following information has been provided to you, verbally and in writing, at least 24 hours prior to the date of your procedure at St. Charles Surgery Center.

1. ***Statement of Financial Interest***: I was advised that my physician may maintain a financial interest in this surgery center.

2. ***Statement of Patient's Rights***: A copy of the Patient's Rights and Responsibilities and Grievance Procedure has been provided to you prior to the date of your initial procedure at this center.

3. ***Advance Directives Notification***: I have been advised of the center's policy on advanced directives. I understand that if I have an advanced directive, a copy will be placed in my chart at this center, however, because of the elective nature of my procedure, the center will not honor those advanced directives. In the case of an emergency, I will be transferred to a hospital and a copy of my advanced directive will be sent to the hospital where I am transferred.