AUTHORIZATION AND AGREEMENTS

Consent to Admission/Treatment: I request and consent to medical care and diagnostic procedures that my attending physician(s) or his /her designees determine are necessary. I acknowledge that the medical care I receive while in the Andover Ambulatory Surgery Center is under the direction of my attending physician(s) and the Surgery Center is not responsible for acts of omission of my attending physician(s).

I understand that I retain no property rights to any tissue samples or bodily fluids removed from my body (specimens) as part of treatment. I further understand that Andover Ambulatory Surgery Center has no obligation to preserve these specimens; that it will retain or dispose of specimens according to its usual procedures.

I understand that I have the right to ask any questions about a proposed treatment (including the identity of any person providing or observing treatment) at any time because medicine is not an exact science and the outcomes of treatment are dependent upon my medical condition. I understand that no guarantees can be made as to the outcome of my care.

Release of Information: I authorize the Andover Ambulatory Surgery Center to release any medical or financial information to a medical care-provider who is performing medical care or a diagnostic test(s) on behalf of, or at the request of my attending physician(s), his/her designees, or the Surgery Center. I authorize Andover Ambulatory Surgery Center, its agencies and designees, to utilize any information in my medical record for quality assurance and risk management activities. By state law, you must be advised that the Information authorized by release may include records, which may indicate the presence of a communicable or venereal disease.

Advanced Directive, Organ/Tissue Donor, Patient's Rights, and Privacy Notice: The patient, or his or her representative, hereby acknowledges having been provided with information regarding patient rights, advance directives, organ tissue donation, and the facility privacy notice. Additional information is available upon request.

Consent to Photograph: I hereby consent to be photographed while receiving treatment at Andover Ambulatory Surgery Center. The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

Personal Property: I understand that Andover Ambulatory Surgery Center is not responsible for lost personal belongings and valuables. Family members or friends should be asked to take money, jewelry, and clothing. I also understand that I should inform the staff if I have dentures, eyeglasses, contact lenses, prosthetics or other items that I need to retain close by for personal functioning and to assure safekeeping.

Disclosure of Physician Ownership:

- Andover Ambulatory Surgery Center, LLC, a Kansas limited liability company (the "Surgery Center') is owned by physicians and meets the federal definition of a physician owned Surgery Center as specified in 42 CFR 489.3. A list of the Surgery Center's physician owners is available upon request.
- You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Andover Ambulatory Surgery Center.
- You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.
- By signing this Authorization and Agreement, you acknowledge that you have read, received, and understand the foregoing Disclosure of Physician Ownership, patient safety measure and notification of financial interest.

INITIALS: _____________

PATIENT INFORMATION

MR #: **FIN#:**
ADT: / / **DOB:** / /
DR:

FINANCIAL RESPONSIBILITY: In consideration of all health care services ("Treatment") provided or to be provided by Andover Ambulatory Surgery Center ("ASC") to the patient named below:

- The Responsible Party named below agrees to be financially responsible and obligated to pay ASC for all of its charges for Treatment of the Patient, provided that the amount of the charges does not exceed ASC's regular and customary charges for the Treatment or what is allowed under applicable law or the Insurance company's or third-party payor's allowed payment plus the normally applicable deductible or co-payment. Any balance due shall be payable upon discharge from ASC. The Responsible Party or Patient shall only be obligated to pay the balance due for ASC charges for Treatment of the Patient not covered by what money ASC receives from the Assignment of Benefits from insurance companies and third-party payors as provided below. **If the insurance company or third-party payor which has a contract with the Responsible Party pays benefit directly to the Responsible Party or the Patient, then the Responsible Party or Patient is obligated to immediately sign or pay over the payment to the benefit of ASC. If the Responsible Party fails this obligation, then the Responsible Party shall remain liable for the ASC charges for Treatment of the Patient, until such charges are paid in full to the extent required by law. THIS LIABILITY INCLUDES ALL COLLECTION & LEGAL FEES INCURRED BY ASC.**

INITIALS: _____________

- The Responsible Party or Patient hereby assigns to ASC all right, title and interest in and to any third-party benefits due from all insurance policies and/or other third-party payors which have a contractual relationship with the Responsible Party to pay charges for the Treatment of the Patient provided by ASC.
- The Responsible Party and the Patient each authorize payment from third-party sources to be made directly to ASC for the Treatment of the Patient, under the terms of all contractual arrangements with insurance companies and/or third-party payors who have contractual arrangements with the Responsible Party. The Responsible Party and Patient further agree to cooperate with ASC in its efforts to secure payments from those third parties. **Again, if payment is not made to ASC but instead is made to the Responsible Party or the Patient, then the Responsible Party is obligated to immediately sign over the payment to the benefit of ASC. If the Responsible Party or Patient fails this obligation, then Responsible Party remains liable for all ASC charges for Treatment of the Patient as provided above. THIS LIABILITY INCLUDES ALL COLLECTION & LEGAL FESS INCURRED BY ASC.**

INITIALS: _____________

- The Patient hereby acknowledges receipt of the ASC Notice of Privacy Practices and consents to let ASC use and disclose the Patient's health information as described in the Notice of Privacy Practices, including health information about substance abuse, psychiatric care, or HIV, if applicable. The Patient also acknowledges receipt of the ASC Patient Bill of Rights.

INITIALS: _____________

- The patient hereby authorizes ASC to release all information contained in the Patient's medical or financial records to assist ASC to get paid or assist in the Treatment of the Patient or in ASC's health care operations, including but not limited to Medicare, Medicaid or insurance company and third-party payors who have contractual relationships with the Patient or Responsible Party, and any agents consultants, subcontractors, auditors, attorneys, billing or collection agents of ASC. The foregoing consent may be revoked by the Patient named below at any time except to the extent that ASC has already acted in reliance upon my earlier consent.

INITIALS: _____________

I have reviewed the Admission Agreement and fully understand its contents and implications.
IF PATIENT IS UNDER THE AGE OF 18, PARENT OR LEGAL GUARDIAN MUST SIGN

____

Signature of Patient, Parent, Legal Guardian, Representative **Date**

____

Relationship to Patient **Date**

____

Signature of Witness **Date**

***The responsible party shall be the individual responsible for payment of ASC's treatment of the Patient and may be the patient himself or herself or a parent or legal guardian.**
****If Legal Guardian or Other Legal Representative for the Patient, please provide your age and relationship to the patient, and the reason why the patient is incompetent or unable to sign. If an emancipated minor, please state whether you have lawfully married or are a legal parent or guardian of a child.**

NOTICE OF PRIVACY PRACTICES

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.

Our Policies and Practices to Protect Your Health Information

Our organization maintains a commitment to keeping patient information secure. We protect personal and health information that we collect about you by maintaining physical, electronic, and procedural safeguards. We will preserve your Protected Health Information in accordance with strict standards of security and confidentiality. We will limit the collection and use of information to a minimum in compliance with applicable law. We will permit only authorized employees, who are trained in the proper handling of your Protected Health Information, to have access to that information. We will require external organizations and business associates to comply with privacy standards and all applicable law. While information is the cornerstone of our ability to provide you with appropriate health care, we are dedicated to safeguarding your information.

How We May Use or Disclose Your Protected Health Information

This notice of privacy practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. Your Protected Health Information is information related to demographic Protected Health Information, health and financial information that may identify you including your past, present or future health care services.

- *For Treatment:* We may use and disclose your Protected Health Information to provide you with medical treatment or services. This includes the coordination or management of your health care with a third party. For example, your protected Health Information may be provided to a health care provider to whom you have been referred to ensure the necessary information to diagnose and determine treatment.
- *For Payment:* We may use and disclose your Protected Health Information to obtain payment for treatment and services provided to you. This may include requirements by your health insurance plan to approve services such as making a determination of eligibility of coverage for insurance benefits, reviewing services provided for medical necessity; and utilization review activities. For example, the information on a bill may contain Protected Health Information that identifies you, your diagnosis, and services or supplies used in the course of treatment.
- *For Health Care Operations:* We may use and disclose health information about you for our health care operations. Those uses and disclosures are necessary to run our facilities and make sure that our patients receive quality care. For example, we may use health information to review our care and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new services are warranted. We may also disclose information to doctors, nurses, technicians, certified nurses or medical aides, students and other personnel for review and learning purposes. We may also combine the health information we have with health information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. However, we may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without knowing the identity of specific patients.
- *Required by Law:* We may disclose your Protected Health Information as required by law. This includes but is not limited to judicial and administrative proceedings pursuant to legal authority; to report information related to victims of abuse, neglect, or domestic violence; and to assist law enforcement officials in their law enforcement duties.
- *Public Health Activities:* We may disclose your Protected Health Information for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury or disability, or for other health oversight activities.
- *Abuse or Neglect:* We may disclose your Protected Health Information to government authorities regarding abuse, neglect, or domestic violence.
- *Health Oversight Activities:* We may disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies include government agencies that oversee the health care system, government benefits programs, other government regulatory programs, and civil rights laws.
- *Judicial and Administrative Proceedings:* We may disclose your Protected Health Information in accordance with lawsuits or other legal proceedings in response to an order of a court or administrative tribunal, subpoena, discovery request, or other lawful process.
- *Law Enforcement Purposes:* We may disclose your Protected Health Information to coroners, medical examiners, or funeral directors to enable them to carry out their lawful duties.
- *Organ/Tissue Donation:* We may use or disclose your Protected Health Information for cadaveric organ, eye, or tissue donation purposes.
- *Research:* We may disclose your Protected Health Information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your Protected Health Information.
- *Health and Safety:* We may disclose your Protected Health Information to avert a serious threat to the health or safety of you or any other person pursuant to the applicable law.
- *Fundraising:* We may use and disclose your Protected Health Information to contact you in a fundraising effort for our organization and its operations. We may disclose health information to a foundation related to us so that the foundation may contact you in raising funds for our organization. If you wish to opt out of receiving fundraising communications, please notify us at the address or phone number listed on page 2.
- *Government Functions:* We may use or disclose your Protected Health Information for specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require such use or disclosure.
- *Workers Compensation:* We may use or disclose your Protected Health Information in order to comply with laws and regulations related to Workers Compensation.
- *Appointments and Treatment Alternatives:* We may use your Protected Health Information to provide appointment reminders, information, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.
- *Business Associate:* In the event we arrange for our Business Associates to provide some of the services we perform, such as having a printing company photocopy your medical records, we may be required to disclose your health information to enable the associates to provide the services. Our associates are also required to protect your health information.

Uses and Disclosures That Require Your Authorization

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are prohibited to use or disclosure your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclosure most psychotherapy notes contained in your protected health information. We will not use or disclosure any of your protected health information that contains genetic information that will be used for underwriting purposes.

Your Rights

This notice provides you with notification of your rights with respect to your Protected Health Information and how you may exercise these rights. Uses and disclosures of your Protected Health Information, except as otherwise permitted or required by law, are subject to your written authorization.

- *You have the right to revoke an authorization to use or disclose Protected Health Information:* You may revoke an authorization for uses and disclosures of Protected Health Information that you have previously authorized to the extent that action has not already been taken.
- *You have the right to restrict disclosure to family members or others involved in your care:* You may notify our organization of a restriction to disclose your Protected Health Information to a family member, other relative, or any other person you identify that is directly associated to such involvement related to your care.
- *You have a right to request a restriction of your Protected Health Information:* You may request a restriction on certain uses and disclosures of your Protected Health Information related to treatment, payment, or health care operations. We are NOT required by law to agree to a requested restriction. If we do agree, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment. Your request must state the specific restrictions requested and to whom you want the restriction to apply
- *You have the right to restrict certain protected health information for services paid out-of-pocket:* If you are paying for a service out-of-pocket, in full, we will restrict disclosure of your protected health information to health plans if requested by you in writing.
- *You have the right to request confidential communication of your health information by alternative means or at alternative locations:* You may request alternative accommodations to obtain your Protected Health Information, and we will not request an explanation from you as to the basis for the request. We will accommodate reasonable requests and arrange for the appropriate alternative methods.
- *You have the right to inspect and obtain a copy of your Protected Health Information upon written request:* You may inspect and obtain a copy of your Protected Health Information that is contained in a designated record set for as long as we maintain the Protected Health Information. Under federal law, you may not inspect or obtain a copy of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and Protected Health Information that is subject to law that prohibits access to Protected Health Information. Depending on the circumstances, a decision to deny access may be reviewed. Please contact our office for additional details regarding access to your medical record and applicable fees.
- *You have a right to request an amendment to your Protected Health Information:* You may request and amendment to information you deem to be inaccurate. We reserve the right to deny your request for an amendment; you have the right to file a statement of disagreement; and we have the right to prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our office for additional details regarding and amendment to you Protected Health Information.
- *You have the right to receive an accounting of uses of disclosures made of your Protected Health Information:* You may request a copy of an accounting log of uses and disclosures of Protected Health Information for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes uses and disclosures prior to the effective date of this notice and in accordance with applicable law when authorization for uses and disclosures are not required. You have the right to receive specific information regarding uses and disclosures within the time frame as required by law.
- *You have the right to receive notice of a breach:* We will notify you if your unsecured protected health information has been breached.
- *You have the right to obtain a paper copy of this notice from us:* Upon request, we will provide you with a copy of the Notice of Privacy Practices from our organization.

Our Obligations

We are required to maintain the privacy of your Protected Health Information and provide you with notice of our legal duties and privacy practices with respect to your information. We must abide by the terms of this notice, and we reserve the right to amend the terms of our notice at any time. We will make any new provisions effective for all Protected Health Information maintained. A revised Notice of Privacy Practices will be made available at the location of your physical service delivery site whenever there is a material change to our privacy practices described in our notice.

Questions and Complaints

To request additional information or should you have questions regarding our privacy practices, please contact the Privacy Officer at the following address or phone number:

Organization: Andover Ambulatory Surgery Center
Address: 1124 W. 21st Street North, Suite 100 Andover, KS 67002
Phone Number: (316) 440-3200

You have the right to file a complaint if you believe that your privacy rights have been violated. You may file a complaint by submitting the complaint in writing to the Privacy Official of our organization at the above address or to the Secretary of the Department of Health and Human Services. Our organization will not take retaliatory action against you for filing a complaint.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:____ Signature:____ Date:_____________________

ANDOVER AMBULATORY SURGERY CENTER
PATIENT BILL OF RIGHTS

1. The patient has the right to considerate and respectful care given by competent personnel.
2. The patient has the right, upon request, to be given the name of his attending practitioner, the names of all other practitioners directly participating in his care, and the names and functions of other persons having direct contact with the patient.
3. A patient has the right to consideration of privacy concerning his own healthcare program. Case discussion, consultation, and examination are considered confidential and shall be conducted discreetly.
4. A patient has the right to have records pertaining to his/her care treated as confidential, except as otherwise provided by law.
5. The patient has the right to expect emergency procedures to be implemented without unnecessary delay.
6. The patient has the right to full information, in layman's terms, concerning diagnosis, treatment, and prognosis, including information about alternative treatments and possible complications.
7. The patient has the right to be informed about unanticipated outcomes of care. The patient's family has the right of informed consent of donation of organs and tissues.
8. The patient has the right to file a grievance or complaint pertaining to the provision of any patient services, including premature discharge, with the Surgery Center, or the grievance or complaint may be directed to the licensing department of the State of Kansas.

Kansas Department on Aging
Adult Care Complaint Program
503 South Kansas
Topeka, Kansas 66603

Abuse, Neglect and Exploitation
Complaint Hot Line:
1-800-842-0078 or fax 1-785-296-0256

For premature discharge concerns, contact:
Kansas Foundation for Medical Care
2947 S.W. Wanamaker Drive
Topeka, Kansas 66614-4193
Phone: 1-800-432-0407 or Fax 1-785-273-5130

Medicare Beneficiary Ombudsman
www.medicare.gov
1-800-MEDICARE
1-800-633-4227

Accreditation Association for Ambulatory Health Care
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
Phone: 847-853-6060 or Fax 847-853-9028

If the patient or family wishes to make the complaint directly to the Surgery Center, the address is:
Andover Ambulatory Surgery Center
1124 West 21st Street North, Suite 100
Andover, Kansas 67002

OR, e-mail complaints to: complaints@ksdh.in.gov

1. The practitioner shall obtain the necessary informed consent prior to the start of a procedure.
2. A patient or, if the patient is unable to give informed consent, a responsible person has the right to be advised when the practitioner is considering the patient as part of a medical care research program or donor program, and the patient or responsible person shall give informed consent prior to actual participation in the program. A patient or responsible person may refuse to continue in a program to which he has previously given informed consent.
3. A patient has the right to refuse drugs or procedures, to the extent permitted by statute and a practitioner shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary to inappropriate.
4. A patient has the right to services without discrimination based on age, race, color, religion, national origin, handicap, disability, sexual orientation, veteran status, or source of payment.
5. The patient who requires communication assistance should have access, where possible, to an interpreter.
6. Each patient, or a designated representative, has the right to access information contained in the patient's medical record, within the limits of state and federal law.
7. The patient has the right to examine and receive a detailed explanation of his bill.
8. A patient has the right to have an advanced directive (such as a living will, healthcare proxy, or durable power of attorney for healthcare) concerning treatment or designating a surrogate decision maker with the intent of that directive to the extent permitted by law. If a copy of the advanced directive is available at the facility and the patient's health status requires transfer to another surgery center, a copy of the advanced directive will be sent with the patient.

9. The patient has the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.
10. The patient has the right to participate in the development and implementation of his or her plan of care and treatment.
11. The patient has the right to have a surrogate (parent, legal guardian, person with medical power of attorney) exercise the patient's rights when the patient is incapable of doing so, without coercion, discrimination or retaliation.
12. The patient has the right to appropriate assessment and management of pain.
13. The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the Surgery Center.
14. The patient has the right to receive care in a safe setting.
15. The patient has the right to be free from all forms of abuse or harassment.
16. The patient has the right to access information contained in his or her clinical records within a reasonable time frame.
17. The Surgery Center must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.
18. The patient has the right to know the reasons for any proposed change in the Professional Staff responsible for his/her care.
19. The patient has the right to know the reasons for his/her transfer either within or outside the Surgery Center.
20. The patient has the right to know the relationship(s) of the Surgery Center to other persons or organizations participating in the provision of his/her care.
21. The patient has the right to be informed of the source of the Surgery Center's reimbursement for his/her services, and of any limitations which may be placed upon his/her care.
22. The patient has the right to be informed of his or her visitation rights, including any clinical restriction or limitation on such rights.
23. The patient has the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner) another family member, or a friend, and has a right to withdraw or deny such consent at any time.
24. The patient has the right not to have visitors restricted, limited, or otherwise denied visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.
25. The patient has the right to be ensured that all visitors enjoy full and equal visitation privileges consistent with patient preferences.

The patient of the admitting Surgery Center has the following responsibilities:

1. The patient must provide accurate and complete information concerning his/her present complaints, past medical history and other matters about his/her health.
2. The patient is responsible for making it known whether he/she clearly understands the course of his/her medical treatment.
3. The patient is responsible for following the treatment plan established by his/her physician, including following the instructions of nurses and other health care professionals as they carry out the physician's orders.
4. The patient is responsible for keeping appointments and for notifying ASC/physician if unable to do so.
5. The patient is responsible for his/her actions should treatment be refused or physician orders are not followed.
6. The patient is responsible for assuring financial obligations are fulfilled.
7. The patient is responsible for following the Surgery Center's policies and procedures.
8. The patient is responsible for being considerate of other patients and Surgery Center personnel.

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Signature of Patient, Parent, Legal Guardian, Representative **Date**

ANDOVER AMBULATORY SURGERY CENTER
1124 West 21st Street, Suite 100
Andover, KS 67002
December 2019