Washington Surgery Center
PATIENT'S BILL OF RIGHTS

1. To considerate and respectful care.
2. To be treated equally regardless of race, color, religion, ancestry, national origin, sex, age, qualified disability handicap or marital status.
3. To know the identity of doctors, nurses and others involved in his care, and they have the right to know when those individuals are students, residents or other trainees.
4. To every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.
5. To be provided with complete information concerning his diagnosis, treatment and prognosis. If it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person on his behalf.
6. To refuse treatment and to refuse any participation in experimental research if he so wishes.
7. To participate in decisions regarding his health care, except when such participation is contraindicated for medical reasons.
8. To continuity of care and may change primary or specialty physicians when available.
9. To ask and be informed of the existence of business relationships among the Washington Surgery Center and educational institutions, other health care providers, or payers that may influence his treatment and care.
10. To examine and receive an explanation of his bill, regardless of source of payment**.**
11. To file a complaint, you may contact any or all of the following:
    - Kayla Hoke, Administrator
      Washington Surgery Center
      16 Chamber Drive
      Washington, MO 63090
      (636)239-9122
    - Secretary of the Department of Health and Senior Services
      912 Wildwood
      P.O. Box 570
      Jefferson City, MO 65102
      (573)751-1588
      http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
    - AAAHC
      5200 Old Orchard Road
      Suite 200
      Skokie, IL 60077
      All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

PATIENT'S RESPONSIBILITIES

1. To provide to the best of your knowledge, accurate and complete information regarding your past and present health status, including allergies, new medications, any new condition not previously listed and to report any unexpected changes to the appropriate physician.
2. To follow the treatment plan recommended by the primary physician involved in your care.
3. To provide an adult to transport you home after surgery.
4. To indicate whether you clearly understand the contemplated course of action and what is expected of you and to ask questions when you need further information.
5. To respect staff and other patients.
6. Your actions if you refuse treatment, leave the facility against the advice of the physician, and/or do not follow the physician's instructions relating to your care.
7. To ensure that the financial obligations of your health care are fulfilled as expediently as possible.

MISSION STATEMENT

We exist to provide superior healthcare services to our patients, their families, and our employees in Franklin County and surrounding areas. We will deal with those we serve in a manner that is professional, courteous, helpful, and cooperative.

Our employees are the key to our success. Recognizing this, they will be treated with respect. Their good performance will be rewarded and they will be provided with opportunities for personal growth and development and they will be encouraged to contribute to decisions of the organization.

Respect, trust, and integrity are paramount to our success and we will act honestly and ethically in all matters and expect the same from others.

We agree to be responsible to the society in which we live and work and will be a positive corporate influence in our community and encourage others to do the same.

DISCLOSURE OF PHYSICIAN OWNERSHIP

The following physicians are partial owners of Washington Surgery Center:

- Chris Ullrich, DO, FACS

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND, HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

1. Uses and Disclosures: Washington Surgery Center is permitted by law to disclose the minimum necessary personal health information of each patient to carry out testing, payment and healthcare operations of Washington Surgery Center. For testing purposes, such disclosure may be made to physicians and other health care providers as necessary to effectuate the appropriate treatment and care of patients. Personal health information may be disclosed to the government or other third-party payers for the purpose of obtaining payment for services provided. Washington Surgery Center may also use personal health information to carry out Washington Surgery Center's daily operations such as scheduling and quality assurance. A list of other examples of disclosure can be obtained from the office upon request.
2. Required Authorizations: Washington Surgery Center will not disclose any patient's personal health information for any purpose aside from payment, treatment and health care operations, without patient's authorized consent to such disclosure. Upon request for such authorization, patients shall have the right to refuse and/or revoke any disclosure at any time.
3. Privacy Compliance: In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164 (the Privacy Regulations), Washington Surgery Center has adopted privacy policies regarding usage of patients' person health information. Washington Surgery Center is committed to compliance with the Privacy Regulations and all other laws regarding patients' rights to privacy.
4. CHANGES TO THIS NOTICE: Washington Surgery Center will abide by the terms of the notice currently in effect. Washington Surgery Center reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that it maintains.

DISCLOSURE OF SPECIALTIES

Washington Surgery Center provides services in the areas of ophthalmology, podiatry, and urology.

Washington Surgery Center
16 Chamber Drive
Washington, MO 63090
(636)239-9122

I, **_____,** hereby acknowledge that I have received and will thoroughly review
(Print Patient Name)
BEFORE my surgery the following documents from the Washington Surgery Center:

1. Patient's Bill of Rights and Responsibilities
2. Mission Statement
3. Disclosure of Physician Ownership
4. Privacy Policy
5. Disclosure of Specialties

I give permission to Washington Surgery Center to leave messages at my
□ Home #_____ □Cell #_____□Work #_____ □Other #_____
that may contain information regarding my appointment and procedure.

I also give permission to discuss any of my appointment/procedure information with the person (s) listed below:
1. Name and Relation: _____Ph#_____
2. Name and Relation: _____Ph#_____
3. Name and Relation: _____Ph#_____

If no names are listed, I understand that no information will be given and if there is no permission to leave a message and no one is able to contact me by the Thursday evening prior to surgery, I *may* have to be rescheduled.

I acknowledge the above listed contact information is by my permission and that I may change it by requesting and filling out another form at any time.

_____ _____
Signature of patient or Responsible Party Date

Upon each appointment at the surgery center, please, review this form, make any needed adjustments and sign and date below.

_____ _____
Signature of patient or Responsible Party Date

_____ _____
Signature of patient or Responsible Party Date

_____ _____
Signature of patient or Responsible Party Date

_____ _____
Signature of patient or Responsible Party Date