RIVER VALLEY
AMBULATORY SURGERY CENTER

PATIENT RIGHTS

- Patients are treated with respect, consideration and dignity.
- Patients have the right to be free from abuse and harassment while at the facility.
- Patients are provided privacy.
- Patient disclosures and records are treated confidentially and patients are given the opportunity to approve or refuse their release, except when such release is required by law.
- Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis. Should it be medically inadvisable to give such information to a patient, the information will be provided to a person designated by the patient or to a legally authorized person.
- Patients are given the opportunity to participate in decisions involving their health care except when such participation is contraindicated for medical reasons.
- Patients have the right to know the services available to them at the facility.
- Patients have the right to be informed of provisions for after-hour and emergency care, if needed.
- Patients have the right to know the facility fee for services.
- Patients have the right to be informed of patient conduct and responsibilities.
- Patients have the right to refuse to participate in experimental research.
- Patients have the right to know the credentials of health care professionals providing their care.
- Patients have the right to change their provider if other qualified providers are available.
- Patients may offer suggestions, voice complaints, and/or grievances regarding their care and/or services provided per state and federal regulations.

PATIENT RESPONSIBILITIES

- Patients must provide complete and accurate information to the best of his/her ability regarding health status: medications taken, including over-the-counter products and dietary supplements; and any known allergies or sensitivities.
- Patients are expected to follow the treatment plan as prescribed by his/her provider.
- Patients must provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours following the procedure if so required by his/her provider.
- Patients are to cooperate with facility personnel and ask questions if directions and procedures are not understood.
- Patients are expected to accept personal financial responsibility for any charges not covered by his/her insurance plans. Patients who receive direct payment from their insurances are expected to submit that payment to us within 10 days of receipt of such payment.
- Patients must be respectful of all health care providers and ancillary staff as well as other patients.

RIVER VALLEY
AMBULATORY SURGERY CENTER

ADVANCED DIRECTIVES

It is the policy of the River Valley Ambulatory Surgery Center to NOT honor "Do Not Resuscitate" (DNR) directives. Regardless, if you have an Advanced Directive, please provide us with a copy so that we may add it to your facility record. If you do not have an existing Advanced Directive and would like information to this end, please let us know. We would be happy to provide you with the necessary forms and facts regarding your Connecticut Healthcare Proxy and Living Will. There are also copies of this document in the back portion of this binder.

KNOWLEDGE OF ESCORT AND AVAILABLE ADULT

I am aware that River Valley Ambulatory Surgery Center requires the following:

1. I can **NOT** drive myself home after my procedure.
2. I must have an escort present at the Center, after the procedure, who will drive me home.
3. I should have a responsible adult available for 24 hours after the procedure.

I understand that it is my responsibility to make these arrangements before arriving at the Center for my procedure. I understand that if these arrangements are not made prior to my arrival my procedure will be canceled.

PERMISSION FOR LEAVING MESSAGES ON VOICEMAIL/ANSWERING MACHINE

I give permission to the personnel of River Valley Ambulatory Surgery Center to leave messages on the voicemail/answering machine of the telephone number(s) I have given to my surgeon as my contact number(s). I understand that this information may include (but is not limited to) pre-operative instructions for my procedure and a follow-up call post-operatively regarding my condition.

*The signature of the patient must be obtained unless the patient is an un-emancipated minor under the age of 18 or is otherwise incapable of signing.

RIVER VALLEY
AMBULATORY SURGERY CENTER

PHYSICIAN OWNERSHIP

The following physicians and entities have ownership in this facility:

Dr. Jerilyn Allen
Dr. David Boisoneau
Dr. Pamela Connors
Dr. William Culviner
Dr. Peter Famiglietti
Dr. Daniel Glenney
Dr. William Kaufold
Dr. Richard Martin
Dr. Vinod Pathy
Dr. Steven Scarangella
Dr. Edward Tarka
Dr. John Wesolek
Dr. Nicole Arcand
Dr. David Colletti
Dr. Darren Courtright
Dr. Frank Dellacono
Dr. Raymond Gaito
Dr. Steven Green
Dr. Gregory Lesnik
Dr. John Pagnozzi
Dr. Stephen Rouse
Dr. Patricia Stuart
Dr. Shri Verma
Dr. Dana Woods
Merritt Healthcare Holdings

COMPLAINTS

You may contact the following for concerns or complaints related to your experience at the surgery center:

Susan Carocari, RN, BSN, CAPA
Administrator
River Valley Ambulatory Surgery Center
(860)859-9948, extension 112
scarocari@rivervalleyasc.com

State of Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
(860)509-7400

RIVER VALLEY
AMBULATORY SURGERY CENTER

Office of the Medicare Beneficiary Ombudsman
www.cms.hhs.gov/center/ombudsman.asp

Benefits Receipt

This notice serves to inform you that after your procedure today, the Center will bill your Insurance Company for services rendered by the facility.

Insurance companies handle claims processing in different ways. Some send payment for services, on the patient's behalf, directly to the Center, while others send payment directly to the patient.

If you receive a payment from your Insurance Company, please call the Center immediately at (860) 859-9948. We will ask that you endorse the check over to The River Valley Ambulatory Surgery Center, and mail us the payment along with a copy of the Explanation of Benefits.

I, the patient, acknowledge that:

- My Insurance Company might send me payment for services rendered by the Facility in relation to my procedure today
- River Valley Ambulatory Surgery Center retains the right to pursue by legal means any payment withheld by the patient

I, the patient, consent that if I received a check from my Insurance Company, I will:

- Call the Center immediately at (860) 859-9948
- Endorse the check over to the River Valley Ambulatory Surgery Center
- Mail the check along with a copy of the Explanation of Benefits, immediately

RIVER VALLEY
AMBULATORY SURGERY CENTER

RIVER VALLEY AMBULATORY SURGERY CENTER 45 Salem Turnpike, Norwich, CT 06360	**FINANCIAL AGREEMENT**

Patient Sticker Here

Date of Procedure:_____

FINANCIAL AGREEMENT: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the Center may disclose portions of my financial and/or medical records to any person or entity who may be liable for all to any portion of the Center's chargers, including but not limited to insurance companies, health care service plans, or worker's compensation carrier(s) as well as to those individuals the Governing Body may deem appropriate to review the medical record for purpose of medical quality assurance/improvement and peer review. Whether signing as the patient of his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay the Center for all such services, at the Center's regular rates and terms, should my insurance company deny payment. I shall also be responsible for any deductible or co-pay owed at the time of service. Should this account be referred for collection to any attorney or collection agency. I shall pay all attorney's fees and collection expenses in connection therewith, if the patient's account is delinquent. I shall be responsible for paying the Center interest on the full outstanding balance at the maximum rate allowed by law.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY – By signing below, the patient/responsible adult hereby agrees to irrevocably assign all medical and/or surgical benefits, to include major medical benefits to which the patients is entitled, including Medicare, Medicaid, Champus, and all other government sponsored programs, private insurance and any other health plans to Diagnostic Endoscopy, LLC (Center) and all their providers including but not limited to laboratories, and clinical care workers. The patient/responsible adult understands that he/she may cancel in writing at any time this request for payment to Center. Medicare will only pay for services that are determined to be "Reasonable and Necessary" under section 1882(a) of Medicare law. **Furthermore, the patient/responsible adult understands that he/she is financially responsible for all services rendered.**

NOTE: Please read the above agreement carefully and make sure that you understand all terms and conditions before signing below. ***If you do not understand, please review contents with staff prior to signing.***

_____ _____

Patient/Responsible Adult Signature Date

_____ _____

Patient/Responsible Adult – Print Name Relationship to patient (if signed by person other than patient)

_____ _____

Interpreter (If required) Signature Date

RIVER VALLEY
AMBULATORY SURGERY CENTER

Fill out this section ONLY if you *accept financial responsibility for the patient for who you have NO legal responsibility.* I, the undersigned person, hereby certify that I have accepted *total financial responsibility* for the above patient, for the care/treatments rendered to the patient by the Center and all their providers including but not limited to: laboratories, and clinical care workers. I understand that I do not currently do not have any legal responsibility to proved financial support for this patient. I also understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatment/services provided to the patient by the Center. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers. ***Please fill in all sections below and sign where indicated.***

Name: Last_____ First_____ Middle Initial ___ Social Security Number_____-_____-_____

Relationship to patient:_____ Home phone number (_____)_____ Date of Birth _____

Address: _____ City:_____ State: _____ Zip code:_____

Driver's License OR Other photo ID #:_____ Type of ID:_____ State Issued:_____

Occupation:_____ Employer:_____ Business Phone Number(____)_____

Signature of Responsible Party:_____ Date:_____

Interpreter (if required): Print name:_____ Signature:_____ Date:_____

RIVER VALLEY
AMBULATORY SURGERY CENTER

To Our Patients:

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 2013 and we are required to abide by the terms of the *Notice of Privacy Practices* currently in effect. We reserve the right to change the terms of our *Notice of Privacy Practices* and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised *Notice of Privacy Practices* from this office.

You may have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us at the above address for more information regarding this notice.

For more information about HIPAA or to file a complaint:

Office for Civil Rights
Department of Health & Human Services
Attn: Patient Safety Act
200 Independence Avenue, S.W., Rm. 509F
Washington, DC 20201
(202) 619-0403
TDD 1-800-537-7697
FAX: (202) 619-3818

Thank you!

RIVER VALLEY
AMBULATORY SURGERY CENTER

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.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data that can be used to identify you. This is health information that is created or received by your healthcare provider, and that relates to your past, present, or future physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information

The Center may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting healthcare operations. Your protected health information may be used or disclosed only for these purposes unless the Center has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA Privacy Regulations or state law. Disclosures of your protected health information for the purposes described in this Notice may be made in writing, orally or by facsimile.

A. Treatment. We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription, to a laboratory to order a blood test, or to a home health agency that is providing care in your home. We may also disclose protected health information to other physicians who may be treating you or consulting with the Center with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurer to get approval for the surgery that we have scheduled. For example, we may need to disclose information to your health insurer to get prior approval for the surgery. We may also disclose protected health information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for your services, we may also need to disclose your protected health information to your insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to the anesthesiologists for their payment of services.

C. Operations. We may use or disclose your protected health information, as necessary, for our own healthcare operations in order to facilitate the function of the practice and to provide quality care to all patients. Healthcare operations include such activities as:

Quality assessment and improvement activities.

- Employee review activities.
- Training programs, including those in which students, trainees, or practitioners in health care learn under supervision.

- Accreditation, certification, licensing, or credentialing activities.
- Review and auditing, including compliance reviews, medical reviews, legal services, and maintaining compliance programs.
- Business management and general administrative activities.
- In certain situations, we may also disclose patient information to another provider or health plan for their healthcare operations.

D. Other Uses and Disclosures. As part of treatment, payment, and healthcare operations, we may also use or disclose your protected health information for the following purposes:

- To remind you of your surgery date.
- To inform you of potential treatment alternatives or options.
- To inform you of health-related benefits or services that may be of interest to you.
- To contact you to raise funds for the Center or an institutional foundation related to the Center. If you do not wish to be contacted regarding fundraising, please contact our Privacy Officer.

II. Uses and Disclosures Beyond Treatment, Payment and Healthcare Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons, including the following:

A. When Legally Required. We will disclose your protected health information when we are required to do so by any federal, state, or local law.

B. When There Are Risks to Public Health. We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury, or disability, as permitted by law.
- To report vital events such as birth or death, as permitted or required by law.
- To conduct public health surveillance, investigations, and interventions, as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA, and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease, as authorized by law.
- To report to an employer information about an individual who is a member of the workforce, as legally permitted or required.

C. To Report Abuse, Neglect or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically required or authorized by law, or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. **<u>In Connection With Judicial and Administrative Proceedings</u>.** We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena, to the extent authorized by state law, if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. **<u>For Law Enforcement Purposes</u>.** We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court ordered warrant, subpoena, summons, or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official, if the Center has a suspicion that your death was the result of criminal conduct.
- In an emergency, in order to report a crime.

G. **<u>To Coroners, Funeral Directors and for Organ Donation</u>.** We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. **<u>For Research Purposes</u>.** We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board or privacy board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. **<u>In the Event of a Serious Threat to Health or Safety</u>.** We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. **<u>For Specified Government Functions</u>.** In certain circumstances, the federal regulations authorize the Center to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the president and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. **<u>For Workers' Compensation</u>.** The Center may release your health information to comply with workers' compensation laws or similar programs.

III. Uses and Disclosures Permitted Without Authorization, but with Opportunity to Object

A. We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose

your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

B. You may object to these disclosures. If you do not object to these disclosures, or we can infer from the circumstances that you do not object, or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures Which You Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights

You have the following rights regarding your health information:

A. **The right to inspect and copy your protected health information.** 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. A "designated record set" contains medical and billing records, and any other records that your physician and the Center uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety, or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy of your medical information, you must submit a written request to the Privacy Officer, whose contact information is listed on the last pages of this Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. **The right to request a restriction on uses and disclosures of your protected health information.** You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The Center is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the Center does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain

circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. The right to request to receive alternative means of confidential communications from us. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. The right to have your physician amend your protected health information. You may request an amendment to protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendment.

E. The right to receive an accounting. You have the right to request an accounting of certain disclosures of your protected health information made by the Center. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a Center directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that took place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. The right to obtain a paper copy of this Notice. Upon request, we will provide a separate paper copy of this notice, even if you have already received a copy of the Notice or have agreed to accept this Notice electronically.

VI. Our Duties

The Center is required by law to maintain the privacy of your health information and to provide you with this Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. If the Center changes its Notice, we will provide a copy of the revised Notice by sending a copy of the Revised Notice via regular mail or through in-person contact.

VII. Complaints

You have the right to express complaints to the Center and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the Center by contacting the Center's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The Center's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. Complaints against the Center can be mailed to the Privacy Officer at the following address:

River Valley Ambulatory Surgery Center
45 Salem Turnpike
Norwich, CT 06360
ATTN: Privacy Officer

The Privacy Officer can be contacted by telephone at **(860) 859-9948.**

IX. Effective Date

This Notice is effective July 2013.