PATIENT REGISTRATION

Patient Name ____ Date of Birth ________________________________

Social Security # ______________________________ Email Address _____________________________________

Mailing Address ____

CITY STATE ZIP CODE

Physical Address (if different) ____

CITY STATE ZIP CODE

Home Phone____________________ Cell Phone ____________________ Work Phone _____________________

Insurance Carrier ____________________________________ Policy # __________________________________

Policy Holder _____________________________________ Date of Birth (Policy Holder) _____________________

Policy Holder's relationship to Patient ____

INSURANCE:

- Some insurance companies require prior authorization for outpatient surgical procedures. It is your responsibility to ensure this has been obtained.

- Our billing company will bill your insurance company for our services. THIS DOES NOT INCLUDE SURGEON, ASSISTANT SURGEON, OR ANESTHESIOLOGIST CHARGES.

- In the event that your health plan determines services to be "not covered," you will be responsible for payment of those services.

- I authorize payment directly to Truckee Surgery Center for services rendered.

SELF PAY:

- I understand that I am responsible for all charges related to my surgery and agree to abide by the financial agreement I have made with your representative.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322 www.mbc.ca.gov

- I acknowledge that I have read the above information. I understand that I am personally responsible for the full payment of all charges for services rendered at Truckee Surgery Center regardless of any insurance coverage I may have.

- I am aware that my surgeon (Jeff Dodd, M.D. or John Foley, M.D.) may have a financial interest in *Truckee Surgery Center*. I understand that I may choose to have my surgery at another facility. I choose to have my surgery at *Truckee Surgery Center*

- **I have received a copy of the Notice of Privacy Practices, information on patient rights, patient responsibilities, advance directive policy and grievance policy.**

"By signing this form, I acknowledge that I have read (or had read to me) and understand the statements and conditions of this form and agree to them. If I am not the patient, I am legally authorized to sign for the patient. Any questions I have asked have been answered to my satisfaction."

SIGNATURE ____**DATE** __________

PATIENT RIGHTS:

• Be informed of your rights both verbally and in writing prior to the date of your procedure in a manner that you or your representative understands.
• Exercise these rights without regard to sex or cultural, economic, educational, or religious background or the source of payment for his/her care.
• Be treated with respect, consideration, and dignity regarding their medical care.
• Provided with appropriate personal privacy, care in a safe setting, and free from all forms of abuse and harassment.
• Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians who will see him/her.
• Receive information from his/her physician about his illness, his/her course of treatment and his prospects for recovery in terms that he/she can understand.
• Receive as much information from his/her physician about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies this information shall include a description of the procedure or treatment, the medically significant risks involved in each, and to know the name of the person who will carry out the procedure or treatment.
• Actively participate in decisions regarding his/her medical care to the extent permitted by law, this includes the right to refuse treatment or change his/her primary physician.
• Disclosures and records are treated confidentially, except when required by law, patients are given the opportunity to approve or refuse their release. Patients have a right to access their own medical record.
• Information for the provision of after-hour and emergency care.
• Information regarding fees for service, payment policies and financial obligations.
• Decline participation in experimental or trial studies.
• Receive marketing or advertising materials that reflects the services of the Center in a way which is not misleading.
• Express their concerns and receive a response to their inquiries in a timely fashion.
• Self-determination including the right to accept or to refuse treatment and the right to formulate an Advance Directive.
• Know and understand what to expect related to their care and treatment.
• Exercise these rights without being subjected to discrimination or reprisal.
• Be informed of any physician financial interests or ownership in the Center prior to the date of your procedure.
• The right to obtain credentialing information for health care providers upon request.

PATIENT RESPONSIBILITIES:

• Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the counter products and dietary supplement and any allergies or sensitivities.
• Ask for an explanation if you do not understand papers you are asked to sign or anything about your own or your child's care.
• Gather as much information as you need to make informed decisions.
• Be available so staff can teach you how to care for yourself or your child; we want to share our knowledge with you, but you must be prepared to learn.
• Follow the care prescribed or recommended for you or your child by the physicians, nurses, and other members of the health care team; remember, if you refuse treatment or do not follow instructions, you are responsible for your actions.
• Respect the rights and privacy of others.
• Assure the financial obligations associated with your own or your child's care are fulfilled.
• Responsible for being respectful of his/her personal property and that of other persons in the Center.
• Take an active role in ensuring safe patient care. Ask questions or state concerns while in our care. If you don't understand, ask again.
• Provide a responsible adult to transport you home from the facility and remain with you for 24 hours, if required by your provider.
• Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

PATIENT CONCERNS AND/OR GRIEVANCES:

Persons who have a concern or grievance regarding Truckee Surgery Center, including but not limited to, decisions regarding admission, treatment, discharge, denial of services, quality of services, courtesy of personnel or any other issue are encouraged to contact the Administrator or write a statement to:
Administrator
Truckee Surgery Center
10770 Donner Pass Rd., Ste. 201,
Truckee, CA 96161
Truckee Surgery Center is Medicare Certified and is accredited by the Accreditation Association for Ambulatory Health Care, Inc. Any complaints regarding services provided at Truckee Surgery Center can be directed in writing or by telephone to:

Department of Public Health
District Manager
850 Marina Bay Parkway
Richmond, CA 94804-6403
(510) 307-8409
OR
AAAHC
5250 Old Orchard Road, Suite 200
Skokie IL 60077
(847) 853-6060
OR
Medicare patients should visit the website below to understand your rights and protections
http://www.cms.hhs.gov/center/ombudsman.asp