

NOTICE TO PATIENTS

It is the philosophy of the Cypresswood Surgery Center to provide patients with the highest level of care throughout their stay in the center. Our goal is to have our patients feel comfortable communicating concerns at any time during their visit however, in the event that a patient or his/her guardian wish to express a complaint to someone other than center staff, the following address and phone number are available:

Texas Department of State Health Services
Facility Licensing Group
1100 West 49th Street
Austin, Texas 78756
888-973-0022

www.dshs.state.tx.us/HFP/complain.shtm

The Cypresswood Surgery Center is owned by the following:

Dr. Mark D. Barhorst and Titan Health Corporation

Signature

Date

Cypresswood Surgery Center/Center for Pain Recovery
9920 Cypresswood Drive, Suite A
Houston, TX 77070
281-469-0069

NOTICE REGARDING ADVANCE DIRECTIVE POLICY

The Center requires the following notice to be signed by each patient in order to be in compliance with the Patient Self Determination Act and State Law.

An Advance Directive is a document or documentation allowing a person to give direction about future medical care or to designate another person to make medical decisions if the individual loses decision making capability. Patients are not required to have an Advance Directive in order to receive treatment at the Center.

There are many types of Advance Directives, but the two most common forms are:

- **Individual HealthCare Instructions.** Instructions explaining wishes regarding health care should the individual be unable to make decisions.
- **Durable Power of Attorney.** A signed, dated, and witnessed document naming another person as an individual's agent or proxy to make medical decisions for that individual should the individual become unable to make decisions.

The type of Advance Directives that may apply to the Center are called "request to forego resuscitative measures" or "do not resuscitate orders (collectively referred to DNR)". A DNR order is typically used by terminally ill patients who do not want to be resuscitated should they suffer cardiac or respiratory arrest threatening situation.

The Center is an outpatient facility, where only elective surgery and/or procedures are preformed, Therefore, all patients shall be presumed as having consented to cardiopulmonary resuscitation when signing the consent for surgery. The Center does not acknowledge "Do Not Resuscitate" orders contained in an Advance Directive. In the unlikely event of a life threatening emergency, the Center policy is to resuscitate, treat, stabilize and transport patients to the hospital as necessary. If a patient has an Advance Directive, a copy will be sent with the patient to the hospital.

Please check the boxes below that apply:

- I have not executed an Advance Directive
- I have executed an Advance Directive
- and it includes a "do not resuscitate order"
 - but it does not include a "do not resuscitate order"
 - but I do not know if it includes a "do not resuscitate" order
- I have provided a copy of my Advance Directive to the Center
- I did not provide a copy of my Advance Directive to the Center

By signing below, I acknowledge that I have consented to resuscitation and transfer to a higher level of care. I have read and fully understand the information contained in this release form.

Patient Signature

Witness to Patient Signature

Date

Date

If patient is unable to sign or is a minor, please sign below:

Witness to relative/guardian's signature

Date

Cypresswood Surgery Center/Center for Pain Recovery
Ethics, Rights, & Responsibilities Manual

The facility observes and respects a patient’s rights and responsibilities without regard to race, color, national origin, culture, disability, age, personal values and religion or belief systems. These rights and responsibilities are posted in the Center’s waiting room to inform all patients and visitors of the Center’s nondiscrimination policy.

<p>The patient has the right to:</p> <ul style="list-style-type: none"> Receive the care necessary to help regain or maintain his or her maximum state of health and, if necessary, cope with death. 	<ul style="list-style-type: none"> Expect the facility to agree to comply with Federal Civil Rights laws that assure it will provide interpretation for individuals who are not proficient in English. The facility presents information in manner and form, such as TDD, large print materials, Braille, audio tapes and interpreters, that can be understood by hearing and sight impaired individuals.
<ul style="list-style-type: none"> Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience, as well as perform the services for which they are responsible with the highest quality of service. 	
<ul style="list-style-type: none"> Expect full recognition of individuality, including personal privacy in treatment and care. In addition, all communications are records will be kept confidential. 	<ul style="list-style-type: none"> Have an initial assessment and regular reassessment of pain.
<ul style="list-style-type: none"> Complete information, to the extent known by the physician, regarding diagnosis, treatment, procedure and prognosis, as well as alternative treatments or procedures and the possible risks and side effects associated with treatment and procedure. 	<ul style="list-style-type: none"> Education of patients and families, when appropriate, regarding their roles in managing pain; as well as potential limitations and side effects of pain treatment, if applicable.
<ul style="list-style-type: none"> Be fully informed of the scope of services available at the facility, provisions for after-hours and emergency care and related fees for services rendered. 	<ul style="list-style-type: none"> Have their personal, cultural, spiritual and/or ethnic beliefs considered when communicating to them and their families about pain management and their overall care.
<ul style="list-style-type: none"> Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient’s rights shall be exercised by the patient’s designated representative or other legally designated person. 	<p>The patient is responsible for:</p>
<ul style="list-style-type: none"> Make informed decisions regarding his or her care. 	<ul style="list-style-type: none"> Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
<ul style="list-style-type: none"> Refuse treatment to the extent permitted by law and be informed of the medical consequences of such a refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility. 	<ul style="list-style-type: none"> Respecting the property of others and the facility Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.
<ul style="list-style-type: none"> Approve or refuse the release of medical records to any individual outside the facility, expect in the case of transfer to another facility, or as required by law or third payment contract. 	<ul style="list-style-type: none"> Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.
<ul style="list-style-type: none"> Be informed of any human experimentation or other research/educational projects affecting his other care or treatment and can refuse participation in such experimentation or research without compromise to the patient’s usual care. 	<ul style="list-style-type: none"> Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient’s condition or any other patient health matters.
<ul style="list-style-type: none"> Express grievances/complaints and suggestions at any time. 	<ul style="list-style-type: none"> Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting the right to care at the facility and is responsible for the outcome.
<ul style="list-style-type: none"> Assistance in changing primary or specialty physicians or dentists if other qualified physicians or dentists are available. 	<ul style="list-style-type: none"> Promptly fulfilling his or her financial obligations to the facility.
<ul style="list-style-type: none"> Provide patient access to and/or copies of his or her individual medical records. 	<ul style="list-style-type: none"> Payment to facility for copies of the medical records the patient may request.
<ul style="list-style-type: none"> Be informed as the facility’s policy regarding advance directives/living wills. 	<p>Should you have any complaints about this facility they should be reported to Texas Department of State Health Services at Hotline # 888-973-0021.</p>
<ul style="list-style-type: none"> Be fully informed before any transfer to another facility or organization to ensure the receiving facility has accepted the patient transfer. 	
<ul style="list-style-type: none"> Express those spiritual beliefs and cultural practices that do not harm or interfere with the planned course of medical therapy for the patient. 	

 Patient Signature

 Witness

 Date

**CYPRESSWOOD SURGERY CENTER/CENTER FOR PAIN RECOVERY/CENTER
FOR PAIN RECOVERY
Privacy Policy Acknowledgement**

I have reviewed CYPRESSWOOD SURGERY CENTER/CENTER FOR PAIN RECOVERY's *Notice of Privacy Practices* prior to signing this document. This Notice of Privacy Practices has been provided to me and is available at the front desk of CYPRESSWOOD SURGERY CENTER/CENTER FOR PAIN RECOVERY lobby. I understand I am entitled to receive a copy of this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of health care operations of CYPRESSWOOD SURGERY CENTER/CENTER FOR PAIN RECOVERY. It also describes my rights and CYPRESSWOOD SURGERY CENTER/CENTER FOR PAIN RECOVERY's duties with respect to my protected health information.

My "protected health information" encompasses health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health and identifies me or provides reasonable basis for identifying me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or CYPRESSWOOD SURGERY CENTER's healthcare operations. CYPRESSWOOD SURGERY CENTER/CENTER FOR PAIN RECOVERY is not required to agree to the restrictions that I may request. However, if CYPRESSWOOD SURGERY CENTER/CENTER FOR PAIN RECOVERY agrees to a requested restriction, that restriction is binding on both the practice and the attending physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that CYPRESSWOOD SURGERY CENTER/CENTER FOR PAIN RECOVERY has taken action in reliance on this consent.

CYPRESSWOOD SURGERY CENTER/CENTER FOR PAIN RECOVERY reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

I consent to the use or disclosure of my **protected health information** by **CYPRESSWOOD SURGERY CENTER/CENTER FOR PAIN RECOVERY** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the practice's health care operations.

Printed Name of Patient or Personal Representative

Date

Signature of Patient or Personal Representative

Signature of Parent if Patient is a Minor

Description of Personal Representative's Authority

Printed Name of Parent if Patient is a Minor

Documentation of Good Faith Efforts

Patient Name _____ Date _____

The patient presented for his/her procedure on this date and was provided with a copy of CYPRESSWOOD SURGERY CENTER/CENTER FOR PAIN RECOVERY's Privacy Notice. A good faith effort was made to obtain a written acknowledgment of receipt of the Notice. However, an acknowledgment was not obtained because:

Patient refused to sign.

Patient was unable to sign or initial because:

There was a medical emergency
(The Center will attempt to obtain acknowledgment
at the next available opportunity).

Other reason, described below:

Signature of employee completing form: _____

**CYPRESSWOOD SURGERY CENTER/CENTER FOR PAIN RECOVERY
PATIENT AUTHORIZATIONS AND AGREEMENTS**

Patient's Name _____

Chart # _____

Your clear understanding of our Financial Policy is important to us:

- Co-pay, co-insurance and deductible payments are due at the time of service. We accept cash, checks, Visa/MasterCard and Discover.
- Parents/Guardians accompanying minor patients are responsible for full payment at the time of service.
- CareCredit financing is available for patients that may need the service.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Cypresswood Surgery Center/Center for Pain Recovery to release any information necessary to my insurance company(ies), including governmental health care insurer (such as Medicare and Medicaid) or other health care facilities and/or practitioners involved in the care of the named patient. I understand that the progress of my treatment may be discussed with my referring physician. I understand that I am giving this authorization only in the case of a subpoena or for the release of information necessary for the provision of continuity of care, to determine insurance benefits and the payment of any claims, and/or for all health plan procedures related to the evaluation of the quality and cost-efficiency of care.

_____ Date _____

RESPONSIBLE PARTY AGREEMENT/ASSIGNMENT OF BENEFITS

I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered, including any supplies or pharmaceuticals that are provided to me in my treatment. I authorize payment of medical benefits to Cypresswood Surgery Center/Center for Pain Recovery for professional services rendered. If any charges are submitted to my insurance carrier by either the Cypresswood Surgery Center/Center for Pain Recovery or by a provider of healthcare services/products/ equipment which are ordered by my physician for the care of the named patient and these services are not covered medical services or are services where benefits are limited and charges above and beyond these limits are incurred, I agree to pay for any balance deemed applicable according to my health insurance rules and regulations. I understand that CSC/CPR will only accept payment from identified payors per insurance card & insurance verification process. I hereby agree that I am responsible for the co-payment, and any deposit required by CSC/CPR. I agree to make payment for these amounts on or before service is rendered. After services have been performed and the claim has been filed, I will be notified by my insurance company when payment has been made to CSC/CPR. I agree to pay any balance within 10 days of that notice. In the event that this account is placed with an attorney or collection agency, the undersigned is responsible for collection fees, reasonable attorney's fees and court costs. If I am not covered by any insurance carrier, I agree to pay for services rendered at the time of service unless other payment arrangements have been made.

_____ Date _____

MEDICARE/ MEDICAID AUTHORIZATION

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to the Cypresswood Surgery Center/Center for Pain Recovery for any services furnished by my physician to the named patient. I understand my signature requests that payment be made directly to the provider of care and that the provider agrees to accept the charge determination of the Medicare/Medicaid carrier as the full charge, and that the insured patient is responsible only for the deductible, co-insurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare/Medicaid carrier. I attest that I am eligible for Medicare and/ or Medicaid coverage.

_____ Date _____

CANCELLATION/"NO SHOW" POLICY

I understand that I must contact CSC/CPR and my physician as soon as possible if I need to cancel/reschedule a procedure. I understand that if I do not cancel a procedure and miss my procedure appointment; my chart will indicate a "no show". I understand that CSC/CPR reserves the right to refuse scheduling of future procedures if there are frequently cancelled appointments and "no show" events.

_____ Date _____

A copy or facsimile of this authorization and agreement shall be considered effective and valid as the original.