

# Skin Cancer Specialists Surgery Center, LLC

## Patient Bill of Rights

Skin Cancer Specialists Surgery Center, LLC is committed to providing comprehensive health care in a manner that acknowledges the uniqueness and dignity of each patient.

1. Patients shall be treated with respect, consideration, and dignity.
2. Every patient shall have full consideration of patient privacy concerning consultation, examination, treatment, and surgery.
3. Every patient shall have the right to confidentiality of all records and communications to the extent provided by law. Patients are given the opportunity to approve or refuse the release of their records, except when release is required by law.
4. Every patient shall have the right to an informed consent for surgery as well as any written material available concerning a particular surgery.
5. Every patient shall have the right to care discussed with, directed by, and agreed upon with the physician as well as the right to refuse to be examined, observed or treated by any facility and/or non-facility staff without jeopardizing access to appropriate medical care and attention.
6. Every patient shall have the right, upon request, to receive written information concerning:
  - a. Services available at Skin Cancer Specialists Surgery Center, LLC
  - b. Provision for after-hours emergency care
  - c. Fee for services and related payment policies
  - d. Methods for expressing grievances and suggestions to the facility
7. If the grievance was not resolved through Skin Cancer Specialists Surgery Center, LLC it can be directed to:

Georgia Department of Community Health  
Attn: Complaints Unit  
2 Peachtree Street N.W., Suite 31-447  
Atlanta, GA 30303-3142  
404-657-5726

### **Ownership**

I understand that the physician on staff at Skin Cancer Specialists Surgery Center, LLC, hereinafter ASC, providing medical services is in face the owner of the facility. The ASC is owned by Mark A. Chastain, MD 100%. I understand that I may choose to have my surgery in a facility that is not owned by physicians. I have been given this option and choose to have my surgery at Skin Cancer Specialists Surgery Center, LLC.

### **Release of Information**

The ASC is hereby authorized to request and/or release any medical records pertinent to the healthcare of the patient from or to, but not inclusive of any insurance carrier, adjustor, attorney, or other healthcare provider.

I understand that the information released to these facilities will be used in furthering or processing claims with the insurance company(s). This authorization is given with full knowledge that such disclosure may result in a denial of insurance coverage for services rendered by a physician of the ASC. The information released will not be given, sold, or transferred to any other person not mentioned above, unless required by law.

### **Assignment of Benefits and My Financial Responsibility**

It is the policy of the ASC to collect payment at the time of visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. However, you are expected to pay any co-pay or deductible at the time of service. If your carrier is out of network, you are expected to pay at time of service, unless other arrangements have been made. I understand that my insurance company may send payments for the rendered services to me. I hereby assign ASC all surgical, medical insurance and/or other benefits, if any, otherwise payable to me for the services rendered. I agree to endorse the check(s) over to the ASC. I understand that if I use the insurance payments for my personal use, I have committed insurance fraud. I hereby authorize and direct payment directly to Skin Cancer Specialists Surgery Center, LLC from the obligor of said benefits. Further, I hereby assign and convey Skin Cancer Specialists Surgery Center, LLC, unless charges for their services have been paid, so much of any cause or action or right of recovery and any payment proceeds relating thereto, that I may have against any third party and direct my attorney, if one has been retained as well as any person or insurance company obligated to pay damages or restitution to me, to deduct the amount of any outstanding bill for Skin Cancer Specialists Surgery Center, LLC any settlement proceeds or other proceeds to be paid directly to me, prior to receiving said proceeds. These assignments will remain in effect until revoked by me in writing. I am aware that any charges not covered by my insurance policy are my responsibility.

I further understand that should any account with Skin Cancer Specialists Surgery Center, LLC be turned over to a collecting agency, I will be responsible for any additional interest on my outstanding balance or charges that may be incurred in the collection of my account.

### **Grievance Procedure**

All alleged grievances will be fully documented, investigated and reported to the Administrator of the ASC. Any substantiated allegation will be reported to the State and/or Local authority. The grievance documentation will include the process for how the grievance was addressed. The patient will be provided a thorough written notice of the decision, within twenty days of receipt of the grievance. Contact information for filing grievances is included in the Patient Bill of Rights. Patient will be kept up to date on the grievance status.

### **Advance Directives**

I understand that I will receive an Advance Directive form if requested. The ASC is not an acute care facility; therefore, regardless of the contents of any advance directive or instructions from a healthcare surrogate, if an adverse event occurs during your treatment, we will initiate resuscitative and any other stabilizing measures and transfer you to an acute care setting for further evaluation. Any information regarding current health care directives or health care power of attorney, or living will, will be shared with the facility where you are transferred.

State Law has provided statutory forms for both the living and durable power of attorney for health care.

### **HIPAA Privacy Notice**

The following notice describes how your medical information may be used and disclosed, and how you can get access to the information. Please review the information carefully.

- Your confidential healthcare information may be released to other healthcare professionals within Skin Cancer Specialists Surgery Center, LLC for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of Skin Cancer Specialists Surgery Center, LLC receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime, or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may **NOT** be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by Skin Cancer Specialists Surgery Center, LLC to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You have the right to restrict the use of your confidential healthcare information. However, Skin Cancer Specialists Surgery Center, LLC may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review the photocopy of any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to receive a copy of this privacy notice upon request. This copy can be in the form of an electronic transmission or on paper.
- Skin Cancer Specialists Surgery Center, LLC is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provided patients with a list of duties or practices that protect confidential healthcare information.
- Skin Cancer Specialists Surgery Center, LLC will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to Skin Cancer Specialists Surgery Center, LLC if you believe your rights to privacy have been violated.

1) Have you executed an Advance Directive or living will? Yes No

2) Have you provided a copy to the ASC (Ambulatory Surgery Center)? Yes No

If yes, please note: DNR's will not be honored.

3) If you have not executed an advance directive or living will, would you like information? Yes No

4) Would you like a copy of the Georgia State Advance Directive form? Yes No

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Please add below who we can share your medical and account information with. Your emergency contact must also be listed on this form in addition to your registration, if you wish for us to share your medical and account information.

**NAME**

**RELATIONSHIP**

**PHONE NUMBER**

_____	_____	_____
_____	_____	_____
_____	_____	_____

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I acknowledge that I have received and understand the Patient Bill of Rights, Ownership, Release of Information, HIPAA Privacy Notice, Assignment of Benefits, My Financial Responsibility, Grievance Procedure, and Advance Directive.

I also request payment of authorized insurance benefits be paid to Skin Cancer Specialists Surgery Center, LLC and authorize release of information to determine payable benefits for services rendered.

Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_