(Confidential)

Patient Name ______________________ Date ____________

Birthdate ____________ Age ____________ Height ____________ Weight ____________

Reason for visit? ______________________

Whom may we thank for your referral? ____________ Newspaper ____________ Other ____________

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period ____________

Date of last Pap Smear ____________

Have you had a mammogram? ____________

Are you pregnant? ____________

Number of children ____________

Conditions

Check (✓) symptoms you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications you are currently taking.

____

____

____

____

Pharmacy Name ______________________ Phone ____________

Allergies

____

____

____

____

____

Health History

Family History

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following:

✓	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates ____________

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which substances you use and describe how much you use.

✓	Substance	Amount
	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to the following:

✓		✓	
	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation ____________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____________ Signature ____________ Date

____________ Reviewed By ____________ Date

CHARLES G. POLSEN, M.D.
Plastic & Reconstructive Surgery

2622 Marina Bay Drive
League City, TX 77573
Telephone (281) 538-6600

REGISTRATION

PLEASE PRINT

Date: ____________________ Home Phone: (_______) _________-__________ Cell: (_______) _________-__________

Patient: ____

Last Name First Name Middle Initial

Responsible Party (if a minor):____

Street Address: ____

City: ______________________________ **State:** ______________ **Zip:** ____________

Email: ______________________________ **Sex:** ☐ M ☐ F **Patient's Age:** __________ **Birth Date:** ____________

Status: ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ____ years

Patient's Employer/School: ____

Business/School Address: ____

City:______________________________ State:______________ Zip:______________

Occupation: ______________________ Business/School Phone: (_______) _________-__________

Spouse (or responsible party) Name: ____________________________ Birthdate: ____________

Business Name & Address: ____

City:______________________________ State:______________ Zip:______________

Occupation: ______________________ Business Phone: (_______) _________-__________

Who is responsible for this account? ______________________ Relationship to Patient: ____________

***Patient SS #** __________-__________-__________

Primary Insurance ____________________________ **Plan Type** ______________

Policy Holder's Name ____________________________ **Policy Holder's DOB** ______________

ID #____________________ **Group #** ______________ **Policy Holder's SS#** ______________

***In case of emergency, who should be notified?** Name:______________________ Relationship:____________

Phone: (_______) _________-__________

How did you learn of our practice? ____

AUTHORIZATIONS

Insurance Assignment and Release

I certify that I have Medical Insurance coverage and assign directly to **Dr. Charles G. Polsen and the facility** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financial responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to be above-names Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X____ ______________________
Signature of Beneficiary, Guardian or Personal Representative Date

X____ ______________________
Please Print Name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary

South Shore Plastic Surgery
Charles G. Polsen, M.D.

Board Certified
Plastic & Reconstructive Surgery
Diplomat American Board of Plastic Surgery
2622 Marina Bay Drive
League City, TX 77573
281-538-6600
Fax 281-535-2800

Authorization for Disclosure of Information

I authorize Dr. Charles Polsen to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in Dr. Charles Polsen's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Patient's
Signature:______________________________________ Date:________________

Witness:____

South Shore Plastic Surgery

Charles G. Polsen, M.D.

Board Certified

Plastic & Reconstructive Surgery

Diplomat American Board of Plastic Surgery

2622 Marina Bay Drive
League City, TX 77573
281-538-6600
Fax 281-535-2800

Authorization For Use and Disclosure of Protected Health Information (PHI)

1. Uses and Disclosure of (PHI)

Your Protected Health Information (PHI) will be used by the Practice or disclosed to others for the purpose of treatment, payment, and healthcare operations, law enforcement or public health safety. The practice will require your consent or authorization to disclose PHI for other purposes.

2. Notice of Privacy

The Practice will give you a Notice of Privacy about policies for disclosure of PHI. You should review this document carefully. It recognizes your rights as a patient and details how your PHI will be disclosed. You must sign this notice and receive a signed copy of the notice.

3. Request for Restrictions to Use or Disclose PHI

You may request a written restriction on the disclosure of your PHI. The practice will agree to your request. It will not use or disclose the restricted PHI. Violation of this agreement will be a violation of the federal privacy standard.

4. Revocation of Authorization or Consent

You may revoke this consent by written statement at any time. The Practice will honor your request. Any use or disclosure of your PHI prior to this date will not be affected by the revocation.

5. Reservation of Right to Change Privacy Practice

The Practice reserves the right to modify the privacy practices outlined in the notice.

6. Signature of Patient or Patient Representative

I have reviewed the authorization form and give my permission to the Practice to use or disclose my health information in accordance with the above authorization and the guidelines of HIPPA regulation.

____
Name of Patient

____
Signature of Patient Date

____
Signature of Patient Representative Relationship

Acknowledgement of Review of
Notice of Privacy Practices

I have reviewed the South Shore Surgicenter's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

______________________________________ ______________

Signature of Patient or Personal Representative Date

____

Name of Patient or Personal Representative

NOTICE OF PRIVACY PRACTICES

Effective: April 14, 2003

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.

Each time you visit a doctor, hospital, pharmacist or any other person that provides you health care services, a record of your visit is made. Typically this record contains information about you, such as reasons why you are seeking medical care, a plan for future care and billing information. The South Shore Surgicenter ("South Shore Surgicenter") (sometimes referred to as "we", "our", or "us") understands that this information, often referred to as your "medical information" or "health information", is personal.

South Shore Surgicenter is required by law to maintain the privacy of your health information, and to provide you with a notice of our legal duties and privacy practices with respect to such information. This Notice of Privacy Practices ("Notice") describes your legal rights, advises you of our privacy practices, and lets you know how South Shore Surgicenter is permitted to use and disclose your Personal Health Information ("PHI"). We will provide you with a copy of the current Notice the first time you receive services from South Shore Surgicenter. We will also visibly post a copy of the current Notice in our facility.

South Shore Surgicenter is required to abide by the terms of the Notice currently in effect. In most situations we may use this information as described in this Notice without your permission (known as an "authorization"), but there are some situations where we may use it only after we obtain your written authorization, if law requires that we do so.

South Shore Surgicenter reserves the right to change our privacy practices and revise our Notice. Such changes will be effective immediately and will apply to all health information that we maintain. The Notice will contain the effective date on the first page. If we have already provided you with a copy of the Notice, and later our privacy practices change and we revise our Notice, you may obtain a copy of the revised Notice by asking for a copy of the current Notice to take home with you the next time you visit or receive health care services from South Shore Surgicenter, or by contacting (281)538-2200, and/or submitting your request in writing to our Privacy Officer at the address noted below.

WHO WILL FOLLOW THIS NOTICE

- South Shore Surgicenter, its employees and personnel.
- Students who are studying to become health care professionals (such as nursing students and medical students) who are authorized by South Shore Surgicenter to observe medical procedures as part of their training.
- Physician who contract with South Shore Surgicenter to utilize the South Shore Surgicenter facility, equipment and staff to perform procedures. However, this Notice applies to such physicians only when they are performing duties contemplated by under their contracts with South Shore Surgicenter and are generating PHI in medical records maintained by South Shore Surgicenter. Many of these physicians maintain private practices and may have different privacy policies and practices relating to their use or disclosure of PHI created or maintained outside of South Shore Surgicenter, such as in their clinic or office. Use of this Notice by such physicians does not mean that they are operating as agents or employees of South Shore Surgicenter, and will not affect the medical decisions made in your care and treatment.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways that we may use and disclose your PHI, and include some examples to explain such uses and disclosures. Not every use or disclosure in a category will be listed.

Some uses and disclosures of PHI may be subject to additional restrictions under federal and state laws and regulations, such as those that apply to substance abuse treatment, HIV?AIDS testing and treatment, and mental health treatment. Under certain circumstances these federal and state laws will provide your PHI with additional privacy protections beyond what is described in this Notice. We may also be further bound by the physician-patient privilege to protect your PHI.

For Treatment

We may use and disclose your health information to provide, coordinate and manage the services, supports, and health care you receive from us and other providers. We may disclose your health information to other doctors, nurses, technicians, home health providers and other persons who may be involved in providing your care. We may share your health information with other health care providers when we consult with them about the services that you receive from South Shore Surgicenter. For example, our staff may discuss your PHI with your primary care physician prior to your undergoing a procedure and may provide your physician with results obtained from the procedure.

For Payment

We may use and disclose your PHI so we can be paid for the services we provide to you. This can include billing a third party, such as Medicare, Medicaid or your insurance company. For example, we may need to provide your insurance plan with information about the services we provide to you (such as a diagnosis code) so we will be reimbursed for those services. Your insurance plan may require some additional clinical information as a condition of payment. We also may need to provide the Medicare program with information to ensure you are eligible for services you are receiving. If you do not which us to release any information to your insurance plan or other third party Payer, you will be responsible for the full cost of the treatment, since insurance plan or other third party Payer will not pay us without that information. We may also provide your PHI to another health care provider or entity for their payment activities (such as another physician that provides you treatment).

For Health Care Operations

We may use and disclose your PHI as necessary for us to operate and to maintain the quality of services that we provide to our patients. For example, we may use your PHI to review the services we provide and the performance of our employees that work with you. We may disclose

your PHI to train our staff and students that may be observing procedures as part of their medical school training. We also may use PHI to study ways to more efficiently manage our organization, for licensing activities or for our continuous quality improvement.

There are also some circumstances that we are permitted to disclose your PHI to another health care provider (such as your primary care physician) for his or her own health care operations.

Business Associates

We may disclose your PHI to certain individuals and companies that we contract with (our "business associates") so that they can perform the job we have asked them to do. For example, we may contract with a billing company to assist us with billing insurance companies and third party Payers so that we can be paid for the services that we provide to you. To protect your PHI, however, we require our business associates to appropriately safeguard your PHI and to meet the same confidentiality standards that we are required to meet.

Appointment Reminders, Treatment and Service Alternatives and Health Related Benefits and Services

We may use and disclose your PHI to contact you to remind you of a scheduled procedure or to contact you about treatment and service alternatives or health-related benefits and services that may be of interest to you.

Marketing Communications

We may use and disclose your PHI to tell you about a product or service to encourage you to purchase the product or service. For example, we may send you a newsletter or other mailing about certain educational programs. We will not, however, sell or distribute your PHI to third parties who do not have a relationship with us unless we have obtained an authorization from you. For instance, we would not release information or patient lists to pharmaceutical companies for those companies' drug promotions unless we have your authorization to do so.

Disclosures to Family and Others

We may disclose your PHI to one of your family members, relatives or close personal friends or to any other person identified by you, but we will only disclose information which we feel is relevant to that person's involvement in your care or the payment for your care. If you are feeling well enough to make decisions about your care, we will follow your directions as to who is sufficiently involved in your care to receive information. If you are not present or cannot make these decisions, we will make a decision based on our experience as to whether it is in your best interest for a family member or friend to receive information about you and how much information they should receive. If there is a family member, or other relative, or close personal friend that you do not want us to disclose your PHI to, please notify the staff that assists you.

We may disclose your PHI to an entity assisting in disaster relief efforts (for example, the American Red Cross) so your family can be notified about your condition, status and location in an emergency.

Required by Law

We will disclose your PHI when we are required to do so by federal, state or local law. For instance, we are obligated to report suspected child abuse to the proper authorities.

Public Health Activities

We may disclose your PHI for public health activities and purposes. For example, we may report PHI to a public health authority that is authorized by law to collect or receive the information for purposes of preventing or controlling disease, neglect, reporting reactions to medication or problems with health care products or notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence

We may disclose PHI to a government authority authorized by law to receive reports of abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities

We may disclose PHI to a health oversight agency for activities authorized by law, including audits, investigation, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight of the health care system, government benefit programs, and entities subject to various government regulations. For example, we must make our books, records and other information available to the government agencies in charge of overseeing Medicare and Medicaid so that we can show these agencies that we are complying with Medicare and Medicaid requirements placed on South Shore Surgicenter.

Judicial and Administrative Proceedings

We may disclose your PHI if we are ordered to do so by a court or administrative tribunal. We may also disclose your PHI in response to a subpoena, discovery requires, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Disclosures for Law Enforcement Purposes

We may disclose your health information in very limited circumstances if asked to do so by a properly identified law enforcement official. However, most other disclosures to law enforcement will only be in response to a court order.

Uses and Disclosures about Decedents

We may release information about a deceased person to a coroner or medical examiner to identify the person, determine the cause of death or perform other duties recognized by law. We may also release a deceased person's PHI to funeral directors as necessary to carry out their duties.

Organ, Eye or Tissue Donation. If you are an organ donor, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissues.

Research

Under certain circumstances, we may use or disclose your PHI for research. Before we disclose PHI for research, the research will have been approved through an approval process that evaluates the needs of the research project with your needs for privacy or your PHI. We may, however, disclose your PHI to a person who is preparing to conduct research to permit them to prepare for the project, but no PHI will leave South Shore Surgicenter during that person's review of the information. Enrollment in most of these research projects can only occur after you have been informed about the study, had an opportunity to ask question, and indicated your willingness to participate in the study by signing a consent form. Other studies may be performed using your PHI without requiring your consent. These studies will not affect your treatment or welfare, and your PHI will continue to be protected. For example, a research study may involve comparing the health and recovery of all patients who received one type of procedure to those who received another for the same condition.

To Avert Serious Threat to Health or Safety

We may use or disclose your PHI if we believe that you present a serious danger of future violence to yourself or another, and the use of disclosure is necessary to alert appropriate parties to such danger. In such cases, we will only share your information with someone able to help prevent the danger. For example, we may make a disclosure to appropriate parties if medical personnel at South Shore Surgicenter determine that you are in such mental or emotional condition as to be dangerous to yourself or another identifiable person.

For Specified Government Functions

In certain circumstances, federal regulation authorize us to use or disclose your PHI to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and other, medical suitability determinations, inmates and law enforcement custody. For example, if you are a member of the Armed Forces, we may use and disclose your PHI to appropriate military command authorities for activities they deem necessary to carry out their military mission.

Workers Compensation

We may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers compensation or similar programs that provide benefits for work-related injuries or illness.

Uses and Disclosure Requiring Your Written Permission

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your specific written permission (sometimes know as an "authorization"). If you provide us permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission to use or disclose your PHI, you may revoke that permission, in writing at any time. If you revoke you permission, we will no longer use or disclose your PHI for the reasons covered by your written permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS WITH RESPECT TO YOUR PERSONAL HEALTH INFORMATION

Although your health record is the physical property of South Shore Surgicenter, the information contained in the record belongs to you. The following describes your rights with respect to your PHI that we maintain.

Right to Request Restrictions

You have the right to request that we restrict the uses or disclosures of your PHI that we may make to carry out treatment, payment, or health care operations. You also have the right to request that we restrict the uses or disclosures we make to a family member, other relative, a close personal friend or any other person identified by you. To request a restriction, you may do so at any time. If you request a restriction, you should do so by submitting your request in writing to our Privacy Officer at the address noted below and tell us: (a) what information you want to limit, (b) whether you want to limit use or disclosure or both, and (c) to whom you want the limits to apply (for example, disclosures to your spouse).

We are not required to agree to any requested restriction. However, if we do agree, we will follow that restriction unless the information is needed to provide emergency treatment. Even if we agree to a restriction, you can let us know later that you do not want us to continue to comply with your request.

Right to Receive Confidential Communications

You have the right to request that we communicate your PHI to you in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. We will not require you to tell us why you are asking for the confidential communication. If you want to request confidential communication, you must do so in writing our Privacy Officer at the address noted below. Your request must state how or where you can be contacted.

We will use our best efforts to accommodate all reasonable requests. However, we may, if necessary, require information from you concerning how payment will be handled. We also may require an alternate address or other method to contact you.

Right to Inspect and Copy

With a few very limited exceptions, you have the right to inspect and obtain a copy of your medical record that we maintain. To inspect or copy this information, you must submit your request in writing to our Privacy Officer at the address noted below. Your request should state specifically what information in the medical record you want to inspect or copy. If you request a copy of the information, we may charge a fee for the costs of copying and, if you ask that it be mailed to you, the cost of mailing. We may deny your request to inspect and copy our medical record in certain very limited circumstances. For example, psychotherapy notes are not part of your medical record, and we are not required to provide such notes to you. In some instances, if you are denied access to your medical record, you may request that the denial be reviewed. Another licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend

You have the right to request an amendment (correction) to your health record if you feel that the information we have about you is incorrect or incomplete. You have the right to request an amendment for as long as we keep the information. To request an amendment, you must submit your request in writing to our Privacy Officer at the address noted below. In addition, you must provide a reason that supports your request. Although you are permitted to request that we amend your health information, we may deny your request if it is not in writing or does not include a reason to support your request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is not longer available to make the amendment;
- Is not part of the health information we keep;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to an "accounting of disclosure". An accounting of disclosures is a list of the disclosures of your PHI that we have made, with some exceptions. To request this list, you must submit your request in writing to your Privacy Officer at the address noted below. You request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a twelve-month period will be free. For additional lists, we may charge you for the costs of providing the list.

Right to Copy this Notice

You have the right to obtain a paper copy of our Notice of Privacy Practices. You may request a copy of our current Notice of Privacy Practices at any time by (1) asking for a copy of the Notice to take home with you the next time you visit or receive health care services at our facility, (2) contacting our Privacy Officer at (281)538-2200, or (3) submitting your request in writing to our Privacy Office at the address noted below.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services.

To file a written complaint with us, please contact our Privacy Officer at (281)538-2200, or send your complaint to the Privacy Officer in care of:
South Shore Surgicenter

2622 Marina Bay Drive

League City, Texas 77573

To file a complaint with the Secretary of the U.S. Department of Health and Human Services – Office for Civil Rights:

Region VI - Dallas (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)
Ralph Rouse, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Voice Phone (214)767-4056
FAX (214)767-0432
TDD (214)767-8940

Questions and Information

If you have any questions or want more information concerning this Notice of Privacy Practices, please contact our Privacy Officer at:
South Shore Surgicenter

2622 Marina Bay Drive

League City, Texas 77573

(281)538-2200

Acknowledgement of Review of
Patient's Rights and Responsibilities

I have reviewed and received the South Shore Surgicenter's Patient's Rights and Responsibilities.

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative

Patient Rights and Responsibility

Policy Statement

To insure South Shore Surgicenter patients are aware of their rights and responsibilities, the rights and responsibilities are posted in a prominent place and provided in verbal and written form in appropriate language, for each patient in advance of the day of the procedure.

Procedures

I. Each patient treated at the South Shore Surgicenter has the right to exercise the following rights without being subjected to discrimination or reprisal:

- A. Be treated with respect, consideration and dignity.
- B. Be given respectful care by competent personnel with consideration of their personal privacy and privacy concerning their medical care.
- C. Be given the name of their attending physician, the names of all other physicians directly assisting in their care, and the names and functions of other health care persons having direct contact with the patient, and Doctor's credentialing.
- D. Be given disclosure of ownership in writing in advance of a procedure.
- E. Be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- F. Have records pertaining to their medical care treated as confidential and, except where authorized by law, patient shall be given the opportunity to approve or refuse their release.
- G. Receive safe care in a setting that is free from abuse and harassment.
- H. Know what South Shore Surgicenter rules and regulations apply to their conduct as a patient.
- I. Expect emergency procedures to be implemented without necessary delay.
- J. Be informed of the South Shore Surgicenter's Policy on Advance Directives.
- K. Absence of clinically unnecessary diagnostic or therapeutic procedures.
- L. Expedient and professional transfer to another facility when medically necessary and to have the responsible person and the facility that the patient is transferred to notified prior to transfer.
- M. Treatment that is consistent with clinical impression or working diagnosis.
- N. Good quality care and high professional standards which are continually maintained and reviewed. An increased likelihood of desired health outcomes.

O. Full information in non-technical language concerning appropriate and timely diagnosis, treatment, prognosis and preventive measures; if it is not medically advisable to provide this information to the patient, the information should be given to the responsible person on his/her behalf.

P. Receive a second opinion concerning the proposed surgical procedure, if requested.

Q. Accessible and available health services; information on after-hour and emergency care.

R. Give an informed consent to the physician prior to the start of a procedure.

S. Be advised of participation in a medical care research program or donor program; the patient should give consent prior to participation in such a program; a patient may also refuse to continue in a program that has previously given informed consent to participate in.

T. Receive appropriate and timely follow-up information of abnormal findings and tests.

U. Receive appropriate and timely referrals and consultation.

V. Receive information regarding "continuity of care".

W. Refuse drugs or procedures and have a physician explain the medical consequences of the drugs or procedures.

X. Appropriate specialty consultative services made available by prior arrangement.

Y. Medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability, or source of payment.

Z. Have access to an interpreter whenever possible.

AA. Be provided with, upon written request, access to all information contained in their medical record.

BB. Accurate information regarding the competence and capabilities of the organization.

CC. Receive information regarding methods of expressing suggestions or grievances to the organization. Suggestions and/or grievances to the Surgery Center may be directed to:

South Shore Surgicenter
Administrator
2622 Marina Bay drive
League City, Texas 77573
281-538-2200

Receive information regarding methods of expressing suggestions or grievances to the State. Suggestions and/or grievances to the State may be directed to:

Texas Department of State Health Services
PO Box 149347
Austin, Texas 98756-9347
Or Contact:
CMS Beneficiary Ombudsman
1-800-633-4227
http://www.medicare.gov/Ombudsman/resources.asp

DD. Appropriate information regarding the absence of malpractice insurance coverage.

EE. Change primary or specialty physicians or dentists if other qualified physicians or dentists are available.

FF. Health Services provided are consistent with current professional knowledge.

GG. Information regarding fees for services and payment policies.

II. Each patient treated at the South Shore Surgicenter has the responsibility to:

A. Provide full cooperation with regards to instructions given by his/her surgeon, anesthesiologist, and operative care (pre and post).

B. Provide the South Shore Surgicenter staff with all medical information that may have a direct effect on the provider at the surgery center.

C. Provide the South Shore Surgicenter with all information regarding third-party insurance coverage and accept personal financial responsibility for any charges not covered by third-party insurance.

D. Provide the South Shore Surgicenter with any information on a living will, medical power or attorney or any other advance directives.

E. Provide a responsible adult for transportation home from the Surgery Center and to remain with the patient for the first 24 hours post-op.

F. Be respectful of all Surgery Center personnel, physicians and other patients in the facility.