MILESTONE
SURGERY CENTER
The benchmark for excellence.

Thank you for choosing Milestone Surgery Center
for your medical procedure.

We want to provide an atmosphere of compassion and understanding with minimal stress to our patients. Our state-of-the-art facility provides the highest quality and convenient outpatient surgery options for our patient's needs.

To ensure that we are meeting our goals, we will be asking you to provide us with feedback. There will be many opportunities for you to share your thoughts on how we measure up, such as:

- Throughout your visit, we welcome and appreciate you sharing your thoughts with any of our staff.
- If at any time during your visit you have a question regarding a process or your safety, we ask that you speak up and share your concerns with our staff. Our goal is to provide a safe, friendly environment in which your concerns are addressed promptly to your satisfaction.
- After your surgery and/or procedure you will receive a phone call from one of our Registered Nurses who will check on your progress.
- After your surgery/procedure, you will receive a Satisfaction Survey. We encourage you to participate in this short survey to provide us with your valuable feedback.

In closing, we appreciate the trust you have placed in us! We will make every attempt to honor that trust by providing the high-quality medical care you expect and deserve. We want your visit to be as pleasant as possible under the circumstances and welcome any comments and suggestions you may have.

**OWNERSHIP DISCLOSURE**

**Physician Owners**

Oscar Aguirre, MD

**11953 Lioness Way, Suite 102 | Parker, Colorado 80134 | *Phone*: 303-414-5535 | *Fax*: 720-484-4928 | info@milestoneasc.com**

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# PATIENT RIGHTS AND RESPONSIBILITIES

***Our Center observes and respects a patient's rights and responsibilities without regard to age, race, color, sex, national origin, religion, culture, physical or mental disability, personal values or belief systems.***

## You have the right to:

- Considerate, respectful and dignified care and respect for personal values, beliefs and preferences.
- Access to treatment without regard to race, ethnicity, national origin, color, creed/religion, sex, age, mental disability, or physical disability. Any treatment determinations based on a person's physical status or diagnosis will be made on the basis of medical evidence and treatment capability.
- Respect of personal privacy.
- Receive care in a safe and secure environment.
- Exercise your rights without being subjected to discrimination or reprisal.
- Know the identity of persons providing care, treatment or services and, upon request, be informed of the credentials of healthcare providers and, if applicable, the lack of malpractice coverage.
- Expect the center to disclose, when applicable, physician financial interests or ownership in the center.
- Receive assistance when requesting a change in primary or specialty physicians or dentists if other qualified physicians or dentists are available.
- Receive information about health status, diagnosis, the expected prognosis and expected outcomes of care, in terms that can be understood, before a treatment or a procedure is performed.
- Receive information about unanticipated outcomes of care.
- Receive information from the physician about any proposed treatment or procedure as needed in order to give or withhold informed consent.
- Participate in decisions about the care, treatment or services planned and to refuse care, treatment or services, in accordance with law and regulation.
- Be informed, or when appropriate, your representative be informed (as allowed under state law) of your rights in advance of furnishing or discontinuing patient care whenever possible.
- Receive information in a manner tailored to your level of understanding, including provision of interpretative assistance or assistive devices.
- Have family be involved in care, treatment, or services decisions to the extent permitted by you or your surrogate decision maker, in accordance with laws and regulations.
- Appropriate assessment and management of pain, information about pain, pain relief measures and participation in pain management decisions.
- Give or withhold informed consent to produce or use recordings, film, or other images for purposes other than care, and to request cessation of production of the recordings, films or other images at any time.
- Be informed of and permit or refuse any human experimentation or other research/educational projects affecting care or treatment.
- Confidentiality of all information pertaining to care and stay in the center, including medical records and, except as required by law, the right to approve or refuse the release of your medical records.
- Access to and/or copies of your medical records within a reasonable time frame and the ability to request amendments to your medical records.
- Obtain information on disclosures of health information within a reasonable time frame.
- Have an advance directive, such as a living will or durable power of attorney for healthcare, and be informed as to the center's policy regarding advance directives/living will. Expect the center to provide the state's official advance directive form if requested and where applicable.
- Obtain information concerning fees for services rendered and the center's payment policies.
- Be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- Expect the center to establish a process for prompt resolution of patients' grievances and to inform each patient whom to contact to file a grievance. Grievances/complaints and suggestions regarding treatment or care that is (or fails to be) furnished may be expressed at any time.
  Grievances may be lodged with the state agency directly using the contact information provided below.

## You are responsible for:

- Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the center.
- Identifying any patient safety concerns.
- Observing prescribed rules of the center during your stay and treatment.
- Providing a responsible adult to transport you home from the center and remain with you for 24 hours if required by your provider.
- Reporting whether you clearly understand the planned course of treatment and what is expected of you and asking questions when you do not understand your care, treatment, or service or what you are expected to do.
- Keeping appointments and, when unable to do so for any reason, notifying the center and physician.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in your condition or any other patient health matters.
- Promptly fulfilling your financial obligations to the center, including charges not covered by insurance.
- Payment to center for copies of the medical records you may request.
- Informing your providers about any living will, medical power of attorney, or other advance directive that could affect your care.

**You may contact the following entities to express any concerns, complaints or grievances you may have:**

| | |
|---|---|
| **CENTER** | **Hayley Hyde, RN, DON/Administrator**<br>(303) 414-5535 Office<br>11953 Lioness Way, Suite 102<br>Parker, CO 80134 |
| **STATE AGENCY** | 303) 730-2376 or by mail at the address above. Complaints or grievances may also be filed through the State of Colorado Office of Public Health at:<br>Director, Health Facilities Division<br>Colorado Department of Public Health & Environment<br>4300 Cherry Creek Drive South<br>Denver, CO 80246-1530 |
| **MEDICARE** | Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman at: http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html |

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# CONSENT TO RESUSCITATIVE MEASURES

## Not a revocation of Advance Directives or Medical Powers of Attorney

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute powers of attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This surgery center respects and upholds those rights.

However, unlike an acute care hospital setting, the surgery center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after your surgery.

THEREFORE, IT IS OUR POLICY, AS A MATTER OF CONSCIENCE AND AS PERMITTED BY COLORADO REVISED STATUTES 15-14-508(2) AND 15-18.7-104, REGARDLESS OF THE CONTENTS OF ANY ADVANCE DIRECTIVE OR INSTRUCTIONS FROM A HEALTH CARE SURROGATE OR ATTORNEY IN FACT, THAT IF AN ADVERSE EVENT OR UNEXPECTED DETERIORATION OCCURS DURING YOUR TREATMENT AT THIS FACILITY WE WILL INITIATE RESUSCITATIVE OR OTHER STABILIZING MEASURES AND TRANSFER YOU TO AN ACUTE CARE HOSPITAL FOR FURTHER EVALUATION. AT THE ACUTE CARE HOSPITAL FURTHER TREATMENT OR WITHDRAWAL OF TREATMENT MEASURES ALREADY BEGUN WILL BE ORDERED IN ACCORDANCE WITH YOUR WISHES, ADVANCE DIRECTIVE OR HEALTH CARE POWER OF ATTORNEY. YOUR AGREEMENT WITH THIS POLICY BY YOUR SIGNATURE BELOW DOES NOT REVOKE OR INVALIDATE ANY CURRENT HEALTH CARE DIRECTIVE OR HEALTH CARE POWER OF ATTORNEY.

**If you do not agree to this policy, we are pleased to assist you to reschedule the procedure.**

Please check the appropriate box in answer to these questions.

Have you executed an advance health care directive, a living will, a power of attorney that authorized someone to make healthcare decisions for you?

☐ Yes. I have an advance directive, living will or healthcare power of attorney

☐ No. I do not receive an advance directive, living will or healthcare power of attorney.

☐ I would like to have information on advance directives.

If you check the first box "yes" to the question above, it is your responsibility to provide us a copy of that document so that it may be made a part of your medical record.

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**By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described**. If I have indicated I would like additional information, I acknowledge receipt of that information.

Patient Signature: _____ Dated: _____

Printed Name: _____

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**If consent to the procedure is provided by anyone OTHER THAN THE PATIENT, this form must be signed by the person providing the consent or authorization.**

***I acknowledge that I have read and understand its contents and agree to the policy as described***.

Signature: _____ Date _____

Printed Name _____

Relationship to Patient: ☐ Parent ☐ Court Appointed Guardian ☐ Attorney in Fact ☐ Health Care Surrogate ☐ Other_____

If the Patient answered **yes** to having an advance directive, living will, or healthcare power of attorney:

☐ A copy was provided and placed in the patient's medical record ❑ A copy was not provided

☐ *Not Applicable (if Patient answered NO)

Facility Representative: _____

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# FINANCIAL RESPONSIBILITY AGREEMENT

## Patient Responsibility

Any fees collected at the time of service and any quotes regarding such fees are estimated based on the information available to us at the time of service. We rely on information provided by the responsible party regarding insurance coverage, information from the responsibility party's insurance company, and procedure fees associated with the CPT codes scheduled/reserved and provided to us by your surgeon. Milestone Surgery Center neither accepts nor assumes billing responsibility for third party providers. Services provided by third party providers, including but not limited to the Surgeon's professional fees, Anesthesia professional services, Surgical Assistants, Laboratory, Radiology, Durable Medical Equipment and Physical Therapy services are billed separate and are the sole responsibility of the responsible party and/or their insurance provider. There may be additional charges should your surgeon perform a procedure that is different from, or in addition to, what was scheduled, or for x-rays, implants, 23-hour observation, or other services which were not scheduled or quoted prior to surgery.

PLEASE NOTE: Agreements with insurance companies vary greatly and it is your responsibility to know what is their portion and what is yours.

## Billing Practices

Milestone Surgery Center will bill the responsible party's insurance company for facility charges. Milestone Surgery Center will also collect any co-payments, co-insurance, and/or deductibles at the time of service. The responsibility party will be billed for any remaining charges not covered by insurance, including co-payments, co-insurance and/or deductibles. Additionally, the responsible party will be billed for facility charges in full should the insurance company deny coverage due to lack of referral, no pre-authorization, lack of proper reporting of incident/accident or lack of individual coverage, where applicable. In the event a check is returned for any reason, a $25.00 charge will be made to your account.

## Payment Arrangements

Payment arrangements are available. Please ask about this option if you are interested. Any payment arrangements should be arranged prior to services being provided.

## Collection Activity

Any account balance that is not paid within 90 days of the date of service may be forwarded to an outside agency for collection follow-up. Any account balance that remains unpaid after this transfer may be eligible for reporting to a credit bureau. Should litigation be necessary to collect an outstanding balance owed, the responsible party agrees to pay all costs of collection including, but not limited to, collection fees, attorney fees, interest and court costs.

## Questions

**If you have any questions, please contact (phone).**

I have read the Financial Responsibilities and understand and agree to this Agreement.

Patient/Responsible Party:_____ Dated: _____

# MILESTONE
## SURGERY CENTER

Patient Name:_____ Email:_____

**PLASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent**: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices**: You have the right to read our *Notice of Privacy Practices* before you decide whether to sign this Consent. Our Notice provides a description of your treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read our *Notice of Privacy Practices* brochure carefully and completely before signing the Consent.

We reserve the right to change our privacy practices as described in our *Notice of Privacy Practices*. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your health information that we maintain.

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our Notice, at any time by contacting:

| | |
|---|---|
| Contact Person: | Hayley Hyde, RN, DON/Administrator |
| Telephone: | 303-414-5535 |
| Email: | hayley.hyde@MilestoneASC.com |
| Address: | 11953 Lioness Way, Suite 102, Parker CO 80134 |

**Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

**PLEASE SELECT ALL THAT APPLY.**

- ☐ **Phone**: I want you to contact me by telephone at _____
  - ☐ Do ☐ Do Not leave messages on my answering machine.
  - ☐ Do ☐ Do Not leave messages with any other person.
- ☐ **Mail**: I want you to contact me at the following address _____
- ☐ **Email**: I want you to contact me at the following email address _____
- ☐ **Fax**: I want you to contact me by fax at _____
- ☐ **Other**: Other requests for confidential communications (*specify*)_____
- ☐ Is there anyone involved in your care, or payment of your care with whom we may share your medical information?
  - ☐ Yes ☐ No If Yes, person's name: _____Relationship: _____

I, have had full opportunity to read and consider the contents of this Consent form and your *Notice of Privacy Practices*. I understand that, by signing this Consent, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

*You are entitled to a copy of this consent after you sign it. Include completed Consent in the patient's chart.*

**Acknowledgement of Receipt of *Notice of Privacy Practices***

I have received a copy of this center's *Notice of Privacy Practices*.

Signature:_____ Date:_____

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# AUTHORIZATION FOR SURGICAL OR OTHER SPECIAL PROCEDURE

I hereby authorize and direct Dr. _____and associates or assistants of his/her choice to perform the following operation and any other procedure as he/she may deem necessary or advisable, on me, my child or ward:

_____

The basic procedures of my surgery and the advantages and the disadvantages, risks and possible complications of the procedure have been explained to me by the doctor. Although it is impossible for the doctor to inform me of every possible complication that may occur, the doctor has answered all my questions to my satisfaction.

As with ALL types of surgery, there is the possibility of other complications due to anesthesia, drugs, reactions or other factors which may involve other parts of my body, including a possibility of brain damage or even death. I am aware that there is a possibility of a hospital transfer in an emergency situation. Since it is impossible to state every complication that may occur as a result of surgery, the list of complications is incomplete.

- I hereby authorize and direct the above named surgeon to arrange for additional services for me, as he/she may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia and the performance of services involving pathology and radiology and I hereby consent thereto.
- I further consent to disposal by surgery center/hospital authorities, in accordance with its accustomed practice, of any tissue or parts, which may be removed.
- I authorize the administration of transfusion of blood products to the above patient as may be deemed advisable in the judgment of the anesthesiologists, patients attending physician, and/or his/her associates or assistants. I understand that blood transfusions are not always successful in producing a desired result. I understand that despite the exercise of due care the transfusion of blood or blood products is always attended with a possibility of some ill effects such as the transmission of hepatitis, AIDS, or certain other diseases, accidental immunization, or allergic reactions. I understand that emergencies do on occasion arise when it may be necessary for the patient's well being to use existing stocks of blood which may not include the most compatible blood types.
- I/We hereby authorize all doctors, pharmacies, Milestone Surgery Center or other institutions rendering care and treatment to furnish the responsible parties and/or insurance companies with full information regarding treatment rendered. (Including copies of their records.)
- I acknowledge that I have been advised by Milestone Surgery Center personnel that I should not drive until the effects of any medications that I receive have worn off. This means I understand that I should not drive until the day after my operation, at the earliest.
- I understand that it is my responsibility to arrange for a responsible adult to drive me home and to be with me for twenty-four (24) hours following surgery.
- I am aware that manufacturer's representatives and other observers may be admitted to the operating or treatment room if I approve and if approved by the physician.
- I hereby consent to the use of video-taping or photography of my surgery at my surgeon's discretion and release Milestone Surgery Center from all liability from claims of any kind for the taking and use of these photographs or tapes.
- In the event of an accidental exposure to my blood and/or bodily fluids by a health care provider, I consent to testing for an infectious disease.
- I am aware that my physician does/does not have ownership interest in Milestone Surgery Center. If I choose to go to another health care facility for this procedure, it will have no effect on my relationship with my physician.
- I release Milestone Surgery Center from ANY responsibility for loss and/or damage to money, jewelry or other valuables brought into the Center.

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# AUTHORIZATION FOR SURGICAL OR OTHER SPECIAL PROCEDURE

I AM STATING THAT I HAVE READ THIS CONSENT (OR IT HAS BEEN READ TO ME), AND I FULLY UNDERSTAND IT AND THE POSSIBLE RISKS, COMPLICATIONS AND BENEFITS THAT CAN RESULT FROM THE SURGERY. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL OF THE ITEMS LISTED IN THESE PARAGRAPHS.

Patient Signature: _____ Date: _____ Time:_____

Witness Signature:_____ Date: _____ Time:_____