Welcome!

Gateway Surgery Center is pleased with the decision you and your physician have made to utilize our facility. We want to make your upcoming visit as comfortable and pleasant as possible.

Our Center was founded to provide patients and physicians with the finest quality health care at an affordable cost. We provide excellent care in a warm, personalized setting. Gateway Surgery Center offers today's most sophisticated outpatient techniques and advances in surgical monitoring and equipment. Procedures are performed in safe, clean surroundings by an experienced, caring staff for those patients whose surgical needs do not require a hospital stay. Because we *specialize in outpatient surgeries and procedures*, we can devote individual time and attention to you. After all, wouldn't you rather be at home that evening, in your own bed or easy chair, surrounded by your family and friends?

We look forward to caring for you or your loved one. The more involved and informed you are, the more pleasant this experience will be. If we can be of any assistance, please call us at (704) 920-7020.

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## EXPECTATIONS

- Please call 704-920-7049 the day before your procedure **from 2:00 p.m. - 4:30 p.m.** for your **arrival** time. Please call Friday for Monday's arrival time.
- You will be asked to arrive 1 to 2 hours prior to your scheduled appointment time to allow for admitting and pre-procedure preparation.
- Please read the sample patient consent form included in this folder prior to your arrival. Please **do not sign** this form; you will be asked to sign an identical form when admitted to our Center.
- If the patient is a minor, this form must be signed by a parent or legal guardian. **If you are not the biological parent, you must provide legal guardianship documentation or custody papers.**
- **If you are the legal guardian of an adult patient, you must bring proof of durable medical power of attorney with you.**
- **Please complete pages 15 and 16 of the packet and bring with you the day of your procedure.**
- Please have your driver/responsible person check in with you at the front desk upon arrival. We will ask that this person provide us with their cell phone number. We request that your driver/responsible person stay at the facility during your procedure.
- If the patient is a child, a parent or guardian **MUST** stay in the facility at all times.
- The use of audio and video recording devices by patients and visitors is prohibited at Gateway Ambulatory Surgery Center.
- Picture ID is required at time of registration. Parent(s) of minors must show picture ID upon arrival.

**Visitor Information:**

- Please see the map (located on the back of this folder) for directions to our Center.
- Parking is provided at no cost.
- We ask that you only leave the center if absolutely necessary. If leaving, you must provide your cell phone number to our staff.
- Refreshments and reading materials are available in our lobby for your convenience.
- WiFi is available in the visitor lobby.
- You may want to bring a sweater or jacket as the lobby can be cool at times.
- Due to safety concerns, children may not be left unattended.
- The doctor will speak to the family or significant others after the patient's surgery/procedure.
- In an effort to maintain the privacy of all patients, only two (2) visitors are allowed in a patient room at one time. Additional visitors will be asked to remain in the waiting room.

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## BEFORE YOUR SURGERY/PROCEDURE

**How can I prepare for my surgery?**

Careful attention to the following instructions will help ensure your comfort and reduce the possibility of complications or delays.

This brochure contains information from your doctor on how to prepare for your surgery/procedure. **Please read these instructions as soon as you receive them.** The instructions will have information on diet and what the doctor needs you to be aware of **before** the surgery/procedure.

- **Important: Fill out the questionnaire located on pages 15 and 16 and bring with you the day of your procedure.** This will help expedite your admission process. We realize you may have already provided this to your doctor; however, it is important on the day of your procedure to double-check this for your safety.
- We make every effort to adhere to scheduled appointment times; however, unforeseen delays may occur.
- **Make arrangements to be driven home by a responsible adult** - This is **required** of all patients. Public transportation (taxi, bus) is only acceptable if accompanied by a responsible adult. **Anyone without a driver will be cancelled or rescheduled for another day.**
- **Do not eat or drink anything** (including water, mints or chewing gum) after midnight the day before surgery, unless indicated otherwise by your physician or anesthesia.
- **Bathe or shower and brush your teeth (taking care not to swallow any water)**, the morning of surgery.
- **Medications:** If you have been told to take a medication that morning, you may take it with a small sip of water.
- **Diabetics:** Please follow your doctor's instructions about your diabetic medication. If you have questions about this, please contact your doctor's office. *If you are taking Diabetic Pills please ask the nurse about specific instructions regarding holding diabetic medications.*
- **Notify your doctor** about any allergies to latex and/or rubber.
- Please complete the list of all current medications you are taking **along with** the questionnaire located in the back of this folder. **You will need to bring this with you on the day of your procedure.**

- **Inform your doctor about any medications** you are taking including aspirin, blood thinners, herbs, vitamins, or diabetic medications OR if you have a pacemaker or internal defibrillator. (If you have asthma, or use an inhaler, please bring your inhaler with you.)
- **It is recommended that you stop smoking** before and after your surgery/procedure.
- **If you suspect that you are pregnant**, please notify your doctor. Anesthesia and certain medications may be harmful to your pregnancy.
- **If you have experienced any health changes or elevated temperature** since your last office visit, **Notify your doctor.**

  Fever, colds, flu, or signs of infection may require your procedure to be postponed. If you are having abdominal or rectal surgery, ask your doctor if you need an enema or bowel prep before arriving.
- **Leave jewelry** (including navel, tongue rings, and other body piercing jewelry), **contact lenses, and other valuables** at home for safekeeping. **Bring** eyeglasses for paperwork.
- **Wear flat,** comfortable slip-on shoes.
- **Wear comfortable, loose, daytime clothing**

  (Special consideration should be given with regard to buttons, sleeves, zippers, etc.)
- **Bring crutches, foot boots, ice buckets**, and other ambulatory aids or supplies that you will need or have been told to purchase by your doctor.
- **Bring picture ID, insurance cards, method of payment, and medical information.** Please check with your insurance company for pre-admission requirements.
- **Please inform your doctor or the Center** if you have any special communication needs. We will attempt to meet your needs.
- **Please notify the Center** if you have any religious or cultural issues that would affect your health care.

## Gateway Statement of Nondiscrimination

Gateway Surgery Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Gateway Surgery Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Gateway Surgery Center 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任 何人。

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## AFTER YOUR SURGERY/PROCEDURE

You will be moved to our fully-equipped post anesthesia care unit where you will remain under close observation by the anesthesiologist and our nurses until you are medically ready to go home. Although the length of stay in the post anesthesia care unit varies according to the type of procedure and your doctor's instruction, most patients are discharged within 1 hour after their procedure.

**What precautions should I take after I am home?**

Your surgeon will provide post-operative instructions regarding diet, rest, and medications. The Center will provide you with a written summary of these instructions.

Please follow these general instructions for your safety after your surgery/procedure:

- YOU MUST HAVE A FAMILY MEMBER, CLOSE FRIEND, OR RESPONSIBLE ADULT DRIVE YOU HOME. (This person must be 18 years or older.) This individual will be responsible for receiving discharge instructions following your procedure.
- PLAN TO HAVE SOMEONE STAY WITH YOU FOR 24 HOURS.
- ARRANGE FOR CARE OF YOUR CHILDREN.

**If you have any unexpected problems, please call your doctor.** A nurse from the Center will attempt to contact you within a day or two after your visit to check on your condition. The nurses who contact you will not have any results of your test or lab work. These results are made available to your referring doctor, and then to the patient according to each doctor's office practice.

# ATTENTION: FAMILIES OF PEDIATRIC PATIENTS

*Children frequently wake up from anesthesia in a confused manner. They may appear irritable, combative, or disoriented during the recovery phase. Do not be alarmed, this is considered a normal reaction to anesthesia in the pediatric population. Although your child may be discharged before their temperament returns to normal, children recover faster when they return to familiar surroundings. Your child will not be discharged until they are in a medically stable condition.*

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# FINANCIAL INFORMATION

## CHARGES:

Charges for Gateway Surgery Center and your Physician are separate. The facility (Gateway Surgery Center) charges include the use of the operating / procedure room, nursing staff, medications and most supplies. Your surgeon, anesthesiologist, certified nurse anesthetist, radiologist and pathologist (if applicable) will bill you separately for their services. Depending on your insurance, the other services billed separately may be out-of-network.

## CONTACTING OUR INSURANCE DEPARTMENT:

When you are scheduled for a procedure and / or surgery by your Physician's Office, we will contact your insurance carrier as a courtesy for verification of coverage.

After identifying the extent of your coverage, we will determine your financial responsibility. In most cases, we should be able to estimate the cost of your surgery / procedure beforehand. We will contact you by phone to make you aware of your financial responsibility. Your responsibility includes co-payments, deductibles, co-insurance, and any out of pocket amounts determined by your insurance carrier. **If you have multiple insurance policies, you may not receive a call to review benefits. Any unpaid balance is due within 60 days of the date of service.** Co-payments are collected prior to services being rendered. Additional financial responsibilites discussed prior to services may also be requested upon admission.

We make every effort to advise you of the amount prior to admission. If you have not been contacted by the Gateway Surgery Center Insurance Verification Department within 48 hours of your procedure, please call 704-920-7089.

## PAYMENTS:

For your convenience, Gateway Surgery Center accepts Master Card, Visa, American Express, Discover, Personal Check (with a valid's driver's license) and cash.

**Uninsured, cosmetic, and self-pay patients will be required to pay for services on or before the admission date.** Patients with verified insurance are encouraged to pay their estimated portion on or before the day of their surgery/procedure.

For your convenience, pre-payment can be made prior to your visit by contacting the Insurance Verification Department at 704-920-7089. Payments may also be made on our website at www.gatewayasc.com under the Patient Information tab.

Gateway Surgery Center will bill your insurance company as a courtesy; however, the remaining balance is the patient's responsibility. **Any unpaid balances are due within 60 days of your visit to avoid collection proceedings.**

The Center is willing to work with patients on an individual basis in regard to financial matters. Interest-free payment plans are offered through a partnership with Care Credit (800-365-8295 or www.carecredit.com). For questions or assistance in applying, please contact our Business Office at 704-920-7045.

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# FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD(S)

I hereby assign to and authorize payment directly to Gateway Surgery Center, LLC all benefits due to me under Medicare, Medicaid or any insurance policy providing benefits for facility charges for services rendered by the facility. I hereby assign the benefits due to me the provider of anesthesia. I authorize and instruct the insurance carrier to make payments of authorized benefits directly to anesthesia provider and hereby authorize release of all records required to act on this request. For Medicare/Medicaid: I authorize release of all records and request that payment of authorized benefits be made in my behalf to the provider of anesthesia. A photostatic copy of this agreement shall be considered as effective and valid as the original.

I irrevocably agree that the facility may disclose to the extent allowed by law, my medical and financial records to (a) any affiliate of the facility, specifically including Gateway Surgery Center, LLC and employees and agents, including entities under contract with same to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to the facility or to me, any person or entity responsible for all or part of the facility's charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred by the facility or by my physician for continued care; (d) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Center for Medicare and Medicaid Services, any government or accrediting agency, or their agents or employees.

I have received, prior to my admission, both verbal and written information on Patient Rights, Advance Directives, and disclosure of physician ownership.

All facility charges are due and owing at discharge. In consideration of the services to be rendered, to the extent not expressly prohibited by law or by the contract between the facility and my third party payer, I HEREBY AGREE, WHETHER I AM SIGNING AS A PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorneys fees and collection expenses whether suit is filed or not. **Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest and/or a collection fee on the unpaid amount up to the maximum amount allowed by law.** I understand that the facility files for reimbursement from my insurer or other payer as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the facility.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due. Positive balances may be applied to any debts on the account.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claims for services/treatment rendered by Gateway Surgery Center. I further understand that I am financially responsible for paying for services rendered, and that it is my responsibility to provide current health insurance information to this facility.

AUTHORIZATION FOR TREATMENT: The undersigned hereby applies for outpatient treatment and/or admission of the patient to Gateway Surgery Center and gives permission to the physician in charge of the patient's care to administer treatment deemed necessary or advisable in the diagnosis and treatment of this patient. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made as to the result of treatment or examination in this facility. I understand that students or residents in various health-related training programs may participate in my care or observe special procedures.

**NOTE: You will be billed seperately for services provided by your surgeon, anesthesiologist, radiology, cardiology, laboratory, and/or certified nurse anesthetist.**

PERSONAL VALUABLES: I hereby release the facility from any responsibility for valuables, money, personal or other possessions which are not deposited with the center for safekeeping.

The use of audio and video recording devices by patients and visitors is prohibited at Gateway Ambulatory Surgery Center.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE: I acknowledge that I have received the attached Privacy Notice.

If Personal Representative's signature appears below, please describe Personal Representative's relationship to the patient.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

PATIENT _____ DATE _____

GUARANTOR_____ DATE _____

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# Medical Care Decisions and Advanced Directives:

### WHO DECIDES ABOUT MY MEDICAL CARE OR TREATMENT?:

If you are 18 or older and have the capacity to make and communicate health care decisions, you have the right to make decisions about your medical / mental health treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say "yes" or "no" to treatment recommended by your doctor or mental health provider. If you want to control decisions about your health / mental health care even if you become unable to make or to express them yourself, you will need an "advanced directive."

### WHAT IS AN ADVANCED DIRECTIVE?:

An Advanced Health Care Directive is a set of directions you give about the health / mental health care you want if you are ever to lose your ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

### DO I HAVE TO HAVE AN ADVANCE DIRECTIVE AND WHAT IF I DON'T?:

Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions, and you have no living will, advance instruction for mental health treatment, or a person named to make medical / mental health decisions for you ("health care agent"), your doctor or health / mental health care provider will consult with someone close to you about your care.

### LIVING WILL ~ WHAT IS A LIVING WILL?:

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally or incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatment that would delay your dying, or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube.

### HEALTH CARE POWER OF ATTORNEY:

In North Carolina, you can name a person to make medical / mental health care decisions for you if you later become unable to decide yourself. This person is called your "health care agent." In the legal document you name who you want your agent to be. You can say what medical treatments / mental health treatments you would want and what you would not want. Your health care agent then knows what choices you would make. You should choose an adult you trust and discuss your wishes with this person before you put them in writing.

## Rights of Patients

- Patients are treated with respect, consideration, and dignity.
- Patients are provided appropriate privacy.
- When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by the patient.
- Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse their release, except when release is required by law.
- Patients have the right to see and request a copy of their health record or other health information. If their health record is maintained electronically, they have the right to request a copy in electronic format.
- Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- Patients have a right to know the services available.
- Patients have a right to provisions for after-hours and emergency care.
- Patients have a right to know the facility fees for services and payment policies.
- Patients have a right to be informed of patient conduct and responsibilities.
- Patients have a right to refuse to participate in experimental research.
- Patients have a right to be notified of the center's policy on Advance Directives, as required by state or federal law and regulations.
- Patients have a right to know the credentials of health care professionals providing their care.
- Patients are informed of their right to change their provider if other qualified providers are available.
- Patients are provided with appropriate information regarding the absence of malpractice insurance coverage.
- Patients are informed about procedures for expressing suggestions, complaints, and grievances, including those required by state and federal regulations.
- N.C. Division of Health Service Regulation, Telephone: 1-800-624-3004, Address: 2711 Mail Service Center, Raleigh, NC 27699-2711.
- Office of the Medicare Beneficiary Ombudsman www.cms.hhs.gov/center/ombudsman.asp

## 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 supplements, and any allergies or sensitivities.
- Follow the treatment plan prescribed by his/her provider.
- Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider.
- Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Be respectful of all the health care providers and staff, as well as other patients.

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The following physicians have an ownership interest in Gateway Surgery Center, along with Carolinas Healthcare System–Northeast (CHS-NE). This means that the fee for the use of this facility may go to these investors. All of these physicians are members of the staff of CHS-NE located nearby. You have the right to choose to have your surgeon perform your surgery at CHS-NE instead of Gateway Surgery Center. Please notify your surgeon so he/she can make the necessary arrangements.

| | | |
|---|---|---|
| Dr. | Mark D. | Aldous |
| Dr. | Thomas K. | Barefoot |
| Dr. | Brittian W. | Beaver |
| Dr. | Michael | Brandner |
| Dr. | Alan | Chiemprabha |
| Dr. | Nirav | Chiniwalla |
| Dr. | Thomas A. | Dalton |
| Dr. | James | Dziadziola, Jr. |
| Dr. | Robert | Erdin |
| Dr. | Andrew | Ferris |
| Dr. | Robert T. | Foust |
| Dr. | Brad | Freidinger |
| Dr. | Sara K. | Hawes |
| Dr. | James G. | Hendrix |
| Dr. | Michael C. | Jones |
| Dr. | David F. | Klein |
| Dr. | F.P. Johns | Langford |
| Dr. | David | Lipsitz |

| | | |
|---|---|---|
| Dr. | Buhilda | McGriff |
| Dr. | Brian | Moore |
| Dr. | Richard | Mostak |
| Dr. | Matthew | Myers |
| Dr. | Richard | Ozment |
| Dr. | Eric J. | Panner |
| Dr. | Vinay | Patel |
| Dr. | Robert P. | Quinn |
| Dr. | Harrison | Rhee |
| Dr. | David F. | Rhodes |
| Dr. | Michael | Ryan |
| Dr. | Jamie | Scaglione |
| Dr. | Brian | Schmidt |
| Dr. | Jeffery S. | Schmidt |
| Dr. | James | Skahen, III |
| Dr. | Anthony | Smith |
| Dr. | Nicholas | Stowell |
| Dr. | Marc | Ward |

Gateway Anesthesiologist Partners

# NOTICE OF PRIVACY PRACTICES

## 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.

**If you have any questions or requests, please contact the Administrator of Gateway Surgery Center at:**
**1025 NE Gateway Court, NE, Concord, NC 28025 • 704-920-7020**
**Effective: April 14, 2003 ~ Modified: June 1, 2013**

### WE ARE COMMITTED TO PROTECTING YOUR HEALTH INFORMATION

We understand that information about you and your health is personal. We are committed to protecting your health information. We use and disclose your health information to provide you with quality care and to comply with certain legal requirements. Your health information will be available to all health care professionals who need access as described in this Notice.

**We are required by law to:**
- Make sure that health information is kept private.
- Give you this Notice explaining our legal duties and privacy practices with respect to your health information.
- Follow the terms of the Notice currently in effect and only use and/or disclose health information as we have described in this Notice.

We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all health information that we maintain. If we do so, we will provide you with the new Notice by:
- Posting the revised Notice in our offices
- Making copies of the revised Notice available upon request (either at our offices or through the contact person listed in this Notice); and
- Posting the revised Notice on our website.

This Notice tells you about the ways we may use and disclose your health information, as well as gives you some examples. We also describe your rights and our obligations for the use and disclosure of your health information. Upon request a packet of information regarding Advance Directives and a copy of this Policy will be available to patients.

Gateway Surgery declines to implement the element of an Advance Directive that deals with a "Do Not Resuscitate" request on the basis of conscience and other reasons permitted under State Law. Gateway Surgery Center will always attempt to resuscitate a patient and transfer that patient to a hospital in the event of deterioration.

### WHO WILL FOLLOW THIS NOTICE?

This Notice applies to all records containing your health information which are generated by Gateway Surgery Center. We will share your health information with each other as necessary to carry out treatment, payment or health care operations. Once participating provider gives you this Notice, you will be considered to have received it from all of the participating providers and we will not be required to give it to you again, unless it is revised. Please note that, for liability purposes each provider specifically named on the front of this Notice is a separate entity and one cannot be help liable for the acts of another.

### WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION

**For Your Health Care Treatment:** We may use and disclose your health information to provide, coordinate or manage your health care and related services, both among ourselves and with others. For example, we may use and disclose your health information when you need a prescription, lab work, or an X-ray, or when you need to be referred to another health care provider.

For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The doctor may also need to tell the dietitian about your diabetes so that you can receive appropriate

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meals. Your doctor may also need to share your health information with a pharmacy so you can get appropriate counseling for the diabetes prescription. Finally, your doctor may share this medical information with another health care provider, such as if you are referred to another doctor.

**To Obtain Payment For Services:** Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services we provide to you. Before you receive scheduled services, we may share information about these services with your health plan so we can ask for approval of payment before we provide the services. We may also share portions of your medical information with billing departments and collection department; insurance companies, health plans and their agents which provide you coverage: consumer reporting agencies (e. g., credit bureaus).

For example, if you broke your leg, we may need to give your health plan information about your condition, the supplies used (such as plaster for your cast or crutches) and the services you received (such as X-rays or surgery). The information is given to our billing department and your health plan so we can be paid or so you can be reimbursed.

**For Health Care Operations:** We may use and disclose health information to conduct our business activities and health care operations, which assist us in improving the quality and cost of the care we provide to you and other patients. This includes disclosing your health information to a hospital, related foundation or to a business associate so they may contact you for fundraising. You may opt out by sending a written request to the contact person listed at the beginning of the Notice. We may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

For example, health care operations include using your health information to develop ways to assist our health care providers in deciding what medical treatment should be provided to others. We may also use your health information to review and evaluate the skills, qualifications, and performance of health care providers taking care of you. We may disclose such information to doctors, nurses, regulating agencies and other health care personnel for educational, research and legally required reporting purposes. We may also need your health information to cooperate with outside accrediting and licensing organizations for either our health care providers or our facilities.

**To Remind You About Your Appointment:** We may use and disclose your health information to remind you about an appointment you have for treatment or medical care.

**Individuals Involved in Your Care or Payment for Your Care.** We may share with a family member, personal representative, friend or other person you identify, your health information that is directly related to their involvement in your care or payment for your care. For example, if you are on a spouse's insurance plan your spouse may have access to a bill explaining your treatment. We may share your health information when it is necessary to notify them of your location, general condition or death. In an emergency, or if you are incapacitated, we will use our professional judgment to decide if it is in your best interest to disclose your health information to a person involved in your care. If you bring family members or others to your appointments and do not tell us that you object to then hearing your medical information, then we are allowed to interpret that as your consent for them to do so.

**Business Associates:** We sometimes hire other people to help us perform our services. We may disclose your health information to them so that they can perform the job we have asked them to do. We require them to protect your health information and keep it confidential. For example, we may hire a transcription service to transcribe parts of your medical record, or a billing and collections agency to bill you or your insurance company for the services rendered or collect payment.

## SPECIAL SITUATIONS

In some situations, we may use or share your health information without your permission or allowing you an opportunity to object.

**Examples of these situations include:**

**When the disclosure is required by law**
**Disclosures for Disaster Relief**
**Disclosures for Public Health Activities** (such as to prevent or control disease, injury, or disability; to report births or deaths; to report child or disabled adult abuse or neglect; to report reactions to medicine or problems with medical products, etc.)
**Disclosures for Law Enforcement**
**Disclosure for Judicial and Administrative Proceedings**
**Disclosure for Health Oversight Activities**
**To Coroners, Medical Examiners and Funeral Directors**
**For Organ, eye or Tissue Donation Purposes**
**Disclosure Relates to Medical Research**
**To Avoid a Serious Threat to Health or Safety**
**For Specialized Government Functions**
**Disclosure for Worker's Compensation**

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## ANY OTHER USE OR DISCLOSURE OF YOUR HEALTH INFORMATION REQUIRES YOUR AUTHORIZATION

Under any circumstances other then those listed above, we will ask for your written authorization allowing us to disclose your health information in a specific situation, you can later cancel your authorization in writing by contacting the person listed at the beginning of this Notice. If you cancel your authorization in writing, we will not disclose your health information after we receive your cancellation, except for disclosures being processed before we received your cancellation.

You have the right to request restrictions on uses and disclosures of your health information: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care, such as a family member or friend. We are not required to agree to your request restrictions. Even if we agree to your request, your restrictions may not be followed in certain special situations.

You may request a restriction requests must be in writing to the contact person listed at the beginning of the Notice. We have forms available for this purpose. In your request you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (such as disclosures to your spouse). You may terminate your restrictions by giving written notice the same way. Note that if you ask us not to disclose health information to your health plan for items or services for which you paid in full and out of pocket we will not disclose the information to the plan.

You have the right to authorize other use and disclosure. This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your authorization to use or disclose your PHI for marketing purposes or for any use or disclosure of psychotherapy notes.

You have the right to request how and where we contact you. For example, you may request that we contact you at work or by e-mail. While we will accommodate reasonable requests, we may ask you to provide us with information on how you will handle payment of your treatment and if there is another address or method of contact. You may request alternative communications by sending a written request to the contact person listed at the beginning of the Notice.

You can ask to see and get a copy of your health record and other health information. These records usually include medical, clinical, billing, and other records used to make decisions about you. In most cases, copies of your health record will be given to you within 30 days, but this time frame can be extended for another 30 days. You may request to see and receive a copy of your health information by sending a written request to the contact person listed at the beginning of the Notice. This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a fee for paper or electronic copies as established by professional, state, or federal guidelines.

There are certain situations in which we are not required to comply with your access request. For example, when the records contain psychotherapy notes or psychiatric/substance abuse notes, records prepared in anticipation of a proceeding or as prohibited by law. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of your denial.

If you provided us permission to use or disclose your health information, you may revoke that permission at any time by giving written notice to the contact person listed at the beginning of the Notice. If you revoke your permission, we will no longer use or disclose your health information for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made before you notify us of your revocation.

You have the right to request that we make amendments to clinical, billing and other records used to make decisions about you. Your request must be in writing, submitted to the contact person on the front of this Notice and include an explanation of your reasons for the amendment. If we accept your request to amend the information, we will make the amendment, inform you that it has been made and make reasonable efforts to inform others of the amendment, including persons you name who have received your health information and those who need the amended information.

We may deny your request for an amendment if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the health information kept by us.
- Is not part of the information which you would be permitted to inspect and copy.
- Is not accurate and complete.

We will respond to your request in writing within 60 days the reason for the denial and describe your right to give us a written statement disagreeing with the denial.

You have the right to request an "accounting of disclosures." This is a list of the disclosures of your health information (though it does not include disclosures made for treatment, payment, or for health care operations, or as authorized by you). This list is known as an "accounting of disclosures." To get this list, you must make your request in writing to the contact person listed at the beginning of the Notice.

**You have the right to receive a privacy breach notice:**
You have the right to receive a written notification if we discover a breach of your unsecured PHI, and determine through a risk assessment that notification is required.

You have the right to request a paper copy of this Notice at any time by calling the contact person on the front of this Notice and requesting one. If you receive this Notice electronically, you are entitled to a written copy as well.

**Medicare Beneficiary Ombudsman:**
Patients who are Medicare beneficiaries, or their representative, have the right to receive information and help they need to understand their Medicare options and to apply their Medicare rights and protections. These rights are in addition to the rights available to all patients. http://www.cms.hhs.gov/ombudsman/resources.asp

## YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you think your privacy rights have been violated by us, or you want to complain to use about our privacy practices, you may send a written statement of your complaint to the person listed on the front of this Notice or call (704) 920-7020. You may also send a written complaint to the United States Secretary of the Department of Health and Human Services at Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, S.W., Atlanta, GA 30303-8909 or call them at 1-877-696-6775.

If you file a complaint, we will not take any action against you or change our treatment of you in any way.

## STATE AND FEDERAL LAWS

Some North Carolina and federal laws require us to protect or disclose your health information in keeping with or in addition to the ways stated in this Notice. For example, state law protects your health information under the doctor-patient privilege. There are also situations when we are required or permitted to disclose your information under the law, such as our obligation to report gun shot wounds. The following are just a few examples of some common situations where state or federal laws require us to protect or disclose your information:

**Treatment for Drug and Alcohol Use:** North Carolina protects your discussions with a mental health provider about your mental health treatment. Treatment received for drug or alcohol use in a federally funded rehabilitation center, federal laws prevent us from releasing that information, except in certain situations such as an emergency or if you threaten to hurt someone; we can disclose the information appropriately.

**Unemancipated Minors:** If you are a minor, you have the right to consent to certain treatments without consent of your parent or guardian: (1) for the prevention, diagnosis and treatment of certain illnesses including venereal diseases; (2) for pregnancy; (3) for abuse of controlled substances or alcohol; and (4) for emotional disturbance. North Carolina has certain requirements for parental or guardian consent for abortions. This information will remain confidential, unless your doctor determines your parents or guardian need to know this information because there is a serious threat to your life or health, or your parents or guardian have specifically asked about your treatment.

**Inspections and Surveys:** Gateway Surgery Center is subject to inspections by state and federal agency and accreditation representatives who may review patient health information, which we are required to provide. For example, the state may ask to review records as part of their review of our license or review of a complaint (you may have certain rights to object to these disclosures). A licensing board may review records when evaluating a provider's qualifications.

GATEWAY
SURGERY CENTER

PLEASE FILL OUT COMPLETELY, DETACH AND BRING WITH YOU ON THE DAY OF YOUR PROCEDURE.

Name: _____ Height: _____ Weight: _____

## PLEASE COMPLETE BEFORE YOU COME IN FOR YOUR SURGERY/PROCEDURE
## PLEASE REMEMBER TO BRING WITH YOU ON THE DAY OF YOUR SURGERY/PROCEDURE

❑ NO KNOWN ALLERGIES

ALLERGIES/SENSITIVITIES TO: (Food, Dietary Supplements, Medications including prescriptions and over-the-counter, environmentals, rubber/latex, or other materials. Please describe type of reaction to each.)

_____
_____
_____
_____
_____
_____
_____

LIST SURGERIES: _____
_____
_____
_____
_____
_____

Barriers:
❑ Hard of Hearing (Aides: R/L/Both)
❑ Blind (R/L/Both)
❑ Foreign Language/Interpreter
❑ Diminished Mental Status
❑ Wheelchair
❑ Cane

Any possibility that you are pregnant?
❑ Yes ❑ No

Date of last menstrual period _____ ❑ N/A

PLEASE CHECK ( ✓ ) IF YOU HAVE A HISTORY OR CURRENTLY HAVE ANY OF THESE CONDITIONS:

❑ High Blood Pressure
❑ Heart Attack
❑ Heart/Chest Pains
❑ Congestive Heart Failure
❑ Heart Bypass Surgery
❑ Heart Valve Replacement
❑ Pacemaker/Internal Defibrillator
❑ Heart Cath/Stent/Angioplasty
❑ Rheumatic Fever
❑ Irregular Heart Rhythm
❑ Valve Disease or Heart Murmur
❑ Smoker - How many packs a day?_____ Quit date?_____
❑ Asthma
❑ Emphysema
❑ Bronchitis
❑ Pneumonia
❑ Difficulty Breathing
❑ Cancer
❑ Kidney Problems
❑ Dialysis
❑ Kidney Stones
❑ Problems Urinating
❑ Liver Problems
❑ Hepatitis
❑ Alcohol Use - How much each day? _____
❑ Glaucoma
❑ Problems Moving Neck/Jaw
❑ Stroke/TIA
❑ Seizures
❑ Myasthenia Gravis
❑ Mental Health Problems
❑ Ulcers
❑ Hiatal Hernia
❑ Heartburn/Acid Reflux
❑ Difficulty Swallowing
❑ Nausea, vomiting, abdominal pain
❑ Constipation or diarrhea
❑ Anemia
❑ Blood Disorders/Bleeds Easily
❑ Clotting Problems
❑ High Cholesterol
❑ Diabetes
❑ Thyroid Problems
❑ Artificial Joints or Metal Implants
❑ Arthritis
❑ Artificial Eyes
❑ Limbs
❑ Eyeglasses/contact lens
❑ Dentures/Partials
❑ Other

GATEWAY SURGERY CENTER

**Please continue on back page.**

MEDICATIONS: Please list all prescription, over-the-counter, herbal, and dietary supplements.

❑ If attaching a list of medications, please include last dose taken.

| MEDICINE | DOSAGE | FREQUENCY | LAST DOSE TAKEN |
|---|---|---|---|
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| | | | |

Patient Signature: _____ Date: _____

RN Signature: _____ Date: _____

Who's driving you home today?

Name: _____

Relationship: _____

Phone: _____

Cell: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone: _____

Cell: _____

GATEWAY SURGERY CENTER