5915 SOUTH RAINBOW BLVD., SUITE 108
LAS VEGAS, NV 89118
WWW.STONCREEKSC.COM
P: 702-227-7959 F: 702-227-6344

Please Print

PATIENT REGISTRATION

_______________________________________ AGE:________ B/DATE:_____/_____/_____ SEX: M F
PATIENT NAE (Last, First, Middle)

____
Street (Include Bldg. #, Apt #, Space #) City State Zip Code

HOME NO: (_____)____________________ CELL NO: (_____)_________________ SOC SEC # ______/______/______

WK NO: (_____)______________________ EMAIL: ____

MARITAL STATUS: ____________________ SPOUSE'S NAME: ________________ SOC SEC # ______/______/______

EMPLOYER NAME: ____ OCCUPATION: __________________

PRIMARY INSURANCE INFORMATION (Please Bring Card to Front Desk)

INS. NAME____ TEL # (_____)________________

____
Street (Include Bldg. #, Apt #, Space #) City State Zip Code

INSURED/SUBSCRIBER NAME: ________________________ RELATIONSHIP: _______________ B/DATE: _______________

____
SUBSCRIBER OR ID # GROUP NO PLAN #/EMP NAME

SECONDARY INSURANCE INFORMATION (Please Bring Card to Front Desk)

INS. NAME____ TEL # (_____)________________

____
Street (Include Bldg. #, Apt #, Space #) City State Zip Code

INSURED/SUBSCRIBER NAME: ________________________ RELATIONSHIP: _______________ B/DATE: _______________

____
SUBSCRIBER OR ID # GROUP NO PLAN #/EMP NAME

____ TEL #: (_____)____________________
Nearest Relative Not Living With Parent

____ TEL #: (_____)____________________
In Case of Emergency, Who Should Be Notified?

TYPE OF PROCEDURE BEING PERFORMED: ____

PHYSICIAN DOING PROCEDURE: ____

____ DATE: _____________________________
SIGNATURE OF PATIENT

____ DATE: _____________________________
SIGNATURE OF LEGAL GAURDIAN

Dear Patient,

Thank you for choosing Stonecreek Surgery Center as your healthcare provider. The following is our financial policy. If you have any questions or concerns about our payment policies, please do not hesitate to contact our Billing Department at (702) 778-6003.

Payment for services is due at the time services are rendered. We accept cash, check or credit card. We will submit an insurance claim on your behalf. You must notify us immediately if your insurance information changes.

You must understand and sign that you acknowledge the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company.
2. You have the right to waive your insurance at any time. If you do not inform us of your insurance carrier information at the time of service, you could be responsible for all fees incurred at the time of service.
3. You are responsible for knowing your insurance benefits. What are non-covered services in your plan? What is your deductible and/or co-payment for outpatient surgery? Does you plan require a primary care physician (PCP) referral? If we can be of assistance, please let us know.
4. You are responsible for any deductible or co-payment that will be applied to the surgery center at the time services are rendered. You may pay by cash, check, credit card, or Care Credit.
5. Returned checks are subject to a return check fee of $25.00.
6. A 1.5% interest rate will be added to any patient outstanding balance over 30 days.
7. Financial arrangements for services must be made prior to services being rendered through the Billing Department at (702) 778-6003.
8. If your account goes to Collections, you are responsible for any Collection fees, Legal fees, and/or Court fees.

I hereby acknowledge that I have read and understand the above read material and agree to the terms.

___________________________________	_____________________________
Patient (patient Representative) Signature	Date

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance company to pay directly to Stonecreek Surgery Center the amount due me for Medical Benefits under this claim. I hereby agree to pay Stonecreek Surgery Center all charges not covered by my insurance company.
I also agree that if any insurance payments are paid directly to me, I will pay Stonecreek Surgery
___________ Center within 15 days of receiving the insurance payment.

MEDICARE/MEDICAL INSURANCE BENEFITS/SOCIAL SECURITY ACT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act about me, to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare Claim. I request that payment of
___________ authorized benefits be made on my behalf.

RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of any medical information necessary to process my insurance claim(s) and request that the payment of all benefits be made to Stonecreek Surgery Center for services described. I also authorize the release of any medical records to other physicians/insurance companies/acute care facilities for services needed in order to render
___________ necessary medical care pertaining to my services with Stonecreek Surgery Center.

______________________________________ ___________________________
Patient (Patient Representative) Signature Date

______________________________________ ___________________________
Witness Date

ACKNOWLEDGEMENTS

Ownership Disclosure

I am aware that my physician may have ownership interest in Stonecreek Surgery Center. I understand that I may choose another facility for the purpose of having the procedure performed. I have decided to have my procedure performed at Stonecreek Surgery Center. I acknowledge I

___________ was notified in advance of the date of the procedure of this disclosure.

Patient Rights and Responsibilities

I acknowledge that I have received a copy of Stonecreek Surgery Center's Patient Right's & Responsibilities in advance of the date of the procedure. I understand that I may address any

___________ question I have regarding this form to the facility's representative.

Advance Directives

I acknowledge that I have received a copy of Stonecreek Center's policy on Advance Directives in advance of the date of the procedure. I understand that I may address any questions I have

___________ regarding the form to the facility's representative.

Notice of Privacy Act

I acknowledge that I have received a copy of Stonecreek Surgery Center's Notice of Privacy Practice in advance of the date of the procedure. I understand that I may address any questions

___________ I have regarding the form to the facility's representative.

_____________________________________ ________________________

Patient (Patient Representative) Signature Date

_____________________________________ ________________________

Witness Date

Dear Patient,

Please **read** and **complete all forms** attached prior to the day of your procedure. The following forms will become part of your permanent medical record and therefore are required to be completed and brought with you the day of your procedure.

Make sure to bring in a picture ID, your insurance card(s), and any money owed for co-payment/deductible/facility fee with you. We accept cash, check, credit cards and Care Credit for payment.

PLEASE LEAVE ALL OTHER VALUABLES AT HOME, INCLUDING JEWELRY

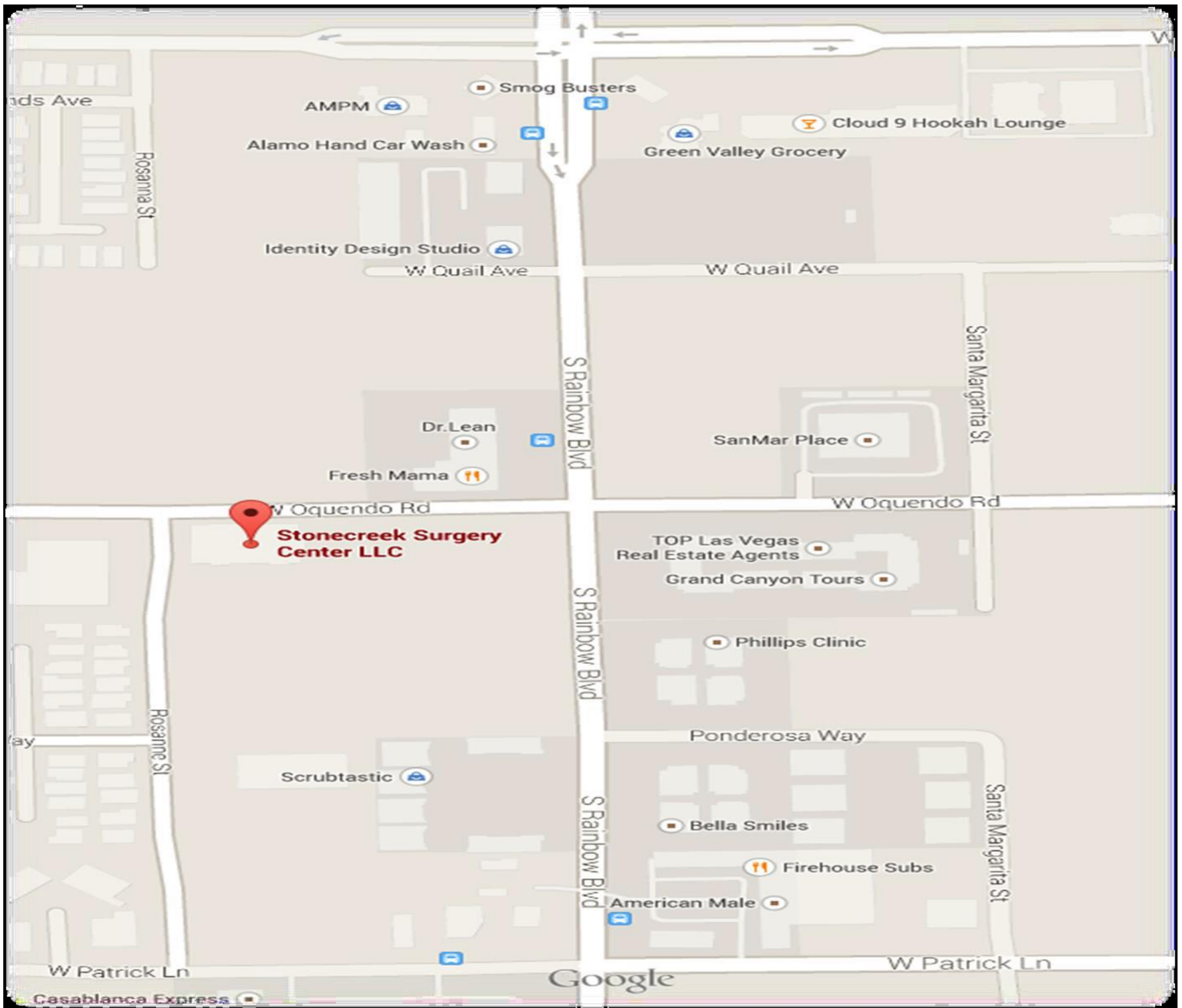
Please be aware that if you are the legal guardian of the patient being seen, documentation (i.e. guardianship paperwork) will be **required** upon check in. Please be sure to bring this paperwork with you in the procedure date.

Please be sure to follow you physician's instructions on preparing for your procedure. Any instructions not followed could cause a delay or cancellation of your procedure.

Please feel free to contact us if you have any questions at (702) 227-7959

Thank you,

Stonecreek Surgery Center



Stonecreek Surgery Center is located at 5915 S. Rainbow Blvd, Suite 108 Las Vegas, NV 89118

Helpful Tips:

- The property **DIRECTLY IN FRONT** of the surgery center (on Rainbow Blvd) is un-developed at the current time.
- The surgery center is located "**OFF**" of Rainbow Blvd. You must turn **"WEST"** (toward the mountain range) onto Oquendo Road and then **"LEFT"** to enter the parking lot.
- There is a LARGE, WHITE, TWO-STORY Building on the corner of Rainbow and Oquendo Road.
- The phone number to the surgery center is (702) 227-7959

PATIENTS RIGHTS & RESPONSIBILITIES

Patient Rights

This facility and medical staff have adopted the following statement of patient rights. These rights are provided to the patient or the patient's representative (as allowed under state law). These rights shall include, but not be limited to, the patient's right to:

- Become informed of his or her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should he or she so desire,
- Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.
- Considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
- Have his or her cultural, psychosocial, spiritual and personal values, beliefs and preferences respected. To assure these preferences are identified and communicated to staff, a discussion of these issues will be included during the initial nursing admission assessment.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her.
- Receive information from his/her physician about his/her illness health status, diagnosis, course of treatment, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she or the patient's representative can understand.
- Receive information about any proposed treatment or procedure he/she may need in order to participate in the development of the plan of care, give informed consent or to refuse the course of treatment and to participate in planning for care after discharge.
    - Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternative courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Formulate advance directives regarding his or her healthcare, and to have facility staff and practitioners who provide care in the facility comply with these directives (to the extent provided by state law and regulations).
- Have a family member or representative of his or her choice notified promptly of his or her visit to the facility, if requested.

- Have his or her personal physician notified promptly of his or her visit to the facility.

- Full Consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and as appropriate, the language of the patient. As appropriate communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his or her medical record within a reasonable time frame (usually within 48 hours of the request).
- Reasonable responses to any reasonable request he/she may make for service.
- Leave the facility even against the advice of his/her physician.
- Reasonable continuity of care.
- Be advised of the grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the facility contact person, the steps taken on his or he behalf to investigate the grievance, the results of the grievance and the grievance completion date.
- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient’s right to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient’s right to a full informed consent to process as it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge.
- Examine and receive an explanation of his/her bill regardless of source of payment.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient’s rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

PATIENTS RESPONSIBILITES

The care a patient receives depends partially on the patient himself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect:

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health.
- The patient is responsible for reporting perceived risks in his or her care and unexpected changes in his/her condition to the responsible practitioner.
- The patient and family are responsible for asking questions about the patient's condition, treatments, procedures, clinical laboratory and other diagnostic test results.
- The patient and family are responsible for asking questions when they do not understand what they been told about the patient's care or what they are expected to do.
- The patient and family are responsible for immediately reporting any concerns or errors they may observe.
- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
- The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her facility care are fulfilled as promptly as possible.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible for being considerate of the rights of other patients and faculty personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.

If you should have a complaint that has not been resolved to your satisfaction, you may contact:

HCQCComplaint
4220 S. Maryland Pkwy, Suite 810, Bldg D
Las Vegas, NV 89199
(702) 486-6515 Phone (702) 486-6520 Fax
HCQCComplaint@health.nv.gov
Accreditation Association for Ambulatory Health Care (AAAHC) Phone: (847) 853-6060

Notice of Advance Directives

Stonecreek Surgery Center strives to provide an atmosphere of respect and caring and to ensure that each patient's ability and right to participate in medical decision-making is maximized and not compromised as a result of admission for care to this facility.

It is the policy of Stonecreek Surgery Center to respect and encourage patient self-determination. Patients will be encouraged and assisted to be active participants in the decision-making process regarding their care through education, inquiry and assistance as requested. Specifically, a patient chooses whether to accept, reject, or continue medical care and treatment.

Stonecreek Surgery Center provides a limited scope of services, specifically limited to interventional surgical services and accompanying ancillary services. Further, the administration of medications that produce a deep sedation necessarily involves some practices and procedures that might be viewed as "resuscitation" in other settings. Thus, a patient who does not desire to have a "do not resuscitate" order suspended shall not be a candidate for treatment at the facility it shall be a condition to treatment at the facility that each patient suspend any "do not resuscitate" order that an otherwise valid and existing advance directive order might contain.

In consenting to the performance of a surgical procedure at Stonecreek Surgery Center, the patient will consent to the full suspension of existing directives during the anesthetic and immediate postoperative period and shall consent to the use of any resuscitation procedures that may be appropriate to treat clinical events that occur during this time. If rescue is required during a procedure and a surrogate requests that a patient not be resuscitated, the surrogate will be informed of the policy of the facility to resuscitate patients in all circumstances.

Stonecreek Surgery Center is an Outpatient Ambulatory Surgical Facility and is therefore not required by law to obtain Advance Directives on all patients. If a patient inquiries about Advance Directives, information or a resource for acquiring information will be provided to the patient.

Information regarding obtaining or initiating Advance Directives is available at our facility. Please inquire through the Registration Department.

Thank you.

5915 S. RAINBOW BLVD., #108
LAS VEGAS, NV 89118
TEL: (702) 227-7959 FAX: (702) 227-6344

NOTICE OF PRIVACY PRACTICE

This document defines your Privacy Rights at Stonecreek Surgery Center as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

<u>EFFECTIVE APRIL 14, 2003</u>

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Stonecreek Surgery Center (SSC)'s required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at Stonecreek Surgery Center, please see the contact information at the end of this document.

I. HOW SCSC MAY USE OR DISCLOSE YOU HEALTH INFORMATION.

SSC collects and protects the privacy of your health information. The law permits SSC to use or disclose your health information for the following purposes:

1. **<u>TREATMENT:</u>** SCSC may use your health information to provide you with medical treatment or services. For example, information obtained from you by front office personnel or nurse is necessary to determine what treatment you should receive.
2. **<u>PAYMENT:</u>** SSC may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, your health information may be sent to a third party payer such as an insurance company or health plan in order for SSC to receive payment for services rendered.
3. **<u>HEALTH CARE OPERATIONS:</u>** SSC may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to: evaluate the performance or our staff; asses the quality of care and outcomes in your case and similar cases; and to determine how to continually improve the quality and effectiveness of health care we provide.
4. **<u>INFORMATION PROVIDED TO YOU AND ON YOUR AUTHORIZATION:</u>** You may give us written authorization to use or disclose your health information.
5. **<u>NOTIFICATION AND COMMUNICATION WITH FAMILY:</u>** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. **<u>REQUIRED BY LAW:</u>** As required by law, we may use and disclose your health information. For example, SSC may disclose health information to the following reasons: judicial and administrative proceedings; to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes; to the Department of Health and Human Services to determine if we are in compliance with federal laws; or to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety or a particular person or the general public.
7. **<u>PUBLIC HEALTH</u>**: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease; injury or disability; report child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; to aid with disaster relief; and reporting disease or infection exposure.
8. **<u>HEALTH OVERSIGHT ACTIVITIES:</u>** We may disclose your health information to health agencies during the course of audits, investigators, inspections, licensure and other proceedings.
9. **<u>DECEASED PERSON INFORMATION AND ORGAN DONATION:</u>** We may disclose your health information to coroners, medical examiners, funeral directors, or to organizations involved in procuring, banking or transplanting organs and tissues.
10. **<u>RESEARCH:</u>** We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

11. **WORKER'S COMPENSATION:** We may disclose your health information as necessary to comply with worker's compensation laws.
12. **MARKETING:** We may contact you to give you information about treatments or health-related benefits and services that may be of interest to you.
13. **GOVERNMENT FUNCTIONS:** Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use of disclosure of your health information.
14. **APPOINTMENTS:** SSC may use your information to provide appointment reminders by phone, email or postal services.
15. **BUSINESS ASSOCIATES:** We work with other businesses to help SSC operate successfully. We may disclose your health information to these business asscociates so that they can perform the tasks we hired them to do . Our business associtates must gaurantee that they will respect the confidentiality of your personal health information.

II. WHEN SSC MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION.

Except as described in this Notice of Privacy Practices, SSC will not use or disclose your health information without your written authorization.

III. YOUR HEALTH INFORMATION RIGHTS.

1. You have the right to request restrictions on certain uses and disclosures of your health information. SSC is not required to agree to the restriction that you requested.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location. Requests must be made in writing detailing the alternative methods chosen and could be applicable to fees.
3. You have the right to inspect and/or obtain a copy of your health information for a reasonable fee.
4. You have a right to request that SSC amend your health information that is incorrect or incomplete. SSC is not required to change your information and will provide you with the information about the denial process.
5. You have a right to receive an accounting of disclosures of your health information made by SSC, except that SSC does not have to account for the disclosures described in treatment, payment, health care operations, and government functions of section I of this notice. The first accounting of disclosures with a twelve-month period is free. Any additional accountings in that time frame are subject to a fee.
6. Your have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
7. You have a right to obtain a paper copy of this Notice upon request.

IV. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

SSC reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, SSC is required by law to comply with this Notice. A paper copy of this Notice is available if you request a copy.

V. COMPLAINTS.

If you believe your privacy rights have been violated, or if you have complaints about this Notice of Privacy Practices contact:

PRIVACY OFFICER
STONECREEK SURGERY CENTER
5915 S. RAINBOW # 108
LAS VEGAS, NV 89118
TEL: (702) 227-7959 FAX: (702) 227-6344

If you are not satisfied with the manner in which SSC handles a complaint, you may submit a formal written complaint to the Department of Health and Human Services, Office for Civil Rights. You will not be retaliated against for filing a complaint.