



HYDE PARK SURGERY CENTER

Patient Compliance

As a reminder prior to your surgery, the following should be discussed with our staff.

- Medical history**
- Details about your procedure**
- Personal belongings**
- Insurance information**
- Transportation**

My Procedure:_____

Day:_____

Date & Time:_____

Physician:_____

Bring this with you the day of surgery.

**HYDE PARK SURGERY CENTER
1644 E. 53RD ST. CHICAGO, IL 60615
Phone-773-752-6340
Fax-773-752-6368**

PATIENTS RIGHTS & RESPONSIBILITIES

The right to confidentiality of his/her clinical records.

The right to access information contained in his/her clinical records within a reasonable time frame (the facility must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits).

The right to know the professional status of any person providing his/her care/service.

The right to know the reasons for any proposed change in the professional staff responsible for his/her care.

The right to know the reasons for his/her transfers either within or outside the facility.

The right to know the relationship(s) of the facility to other persons or organizations participating in the provision of his/her care.

The right to access to the cost, itemized when possible, of services rendered within a reasonable period of time.

The right to be informed of the source of the facility's reimbursement for his/her services, and of any limitations which may be placed upon his/her care.

The right to be free from restraint or seclusion, of any form, imposed as (restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member or others and must be discontinued at the earliest possible time).

The right to be free from physical or mental abuse, and or corporal punishment.

You have a right to have an Advanced Directive, such as a living will or healthcare proxy. It is our policy of this facility NOT to honor an Advanced Directive. Therefore, a copy of your executed advance directive will not be part of your medical record at this facility.

The right to have pain treated as effectively as possible.

The Right to communicate complaints or grievances regarding his/her care to his/her Physician, nurse team member, consumer advocate, or surgical center administrator.

It is also your right to contact the following to report questions or complaints.

Office Of The Medicare Ombudsman: 1-800-633-4227, for TTY users-1-877-486-2048, or on the web-
<http://www.medicare.gov/ombudsman/resources.asp>

You may also contact the Administrator for information regarding initiation, review and resolution of your complaints. The Hyde Park Surgery Center administrator is, Dr. Fortunée Massuda who can be reached by telephone 773-752-6340. We hope you will give us an opportunity to resolve any issues you may have. A written complaint can also be made to the Administrator, Dr. Massuda of the Hyde Park Surgery Center at 1644 E. 53rd St. Chicago, IL 60615. We will respond to all complaints within 10 business days. Complaints may also be communicated directly to the Illinois Department of Public Health at 217-782-7412 ATTN: Karen Devine or to 525 W. Jefferson St 2nd Fl, Springfield, IL 62761 or e-mail at mailus@idph.state.il.us or the Illinois Foundation of Quality Health Care at their consumer helpline at 800-647-8089.

THE PATIENT HAS THE RESPONSIBILITY TO:

Take an active role in his/her medical treatment.

Give information on past illnesses, hospitalizations, medications and any information relating to his/her health.

Inform staff of his/her wishes regarding end of life decision. (I.e. Advance Directives).

Ask questions if instructions and information are not understood.

Following instructions and advice offered by staff.

Report changes in his/her condition to those responsible for his/her care.

Be considerate and respectful of the rights of the other patients and staff.

Honor the confidentiality and the privacy of the other patients.

Follow rules outlined by the department in which being treated.

Cooperate in the planning of his/her discharge.

Pay his/her bill for services received as soon as possible.

ADVANCED DIRECTIVES

PURPOSE The presence of an Advance Directive in a medical record indicates the patient’s preference for continued medical care and should be noted/followed.

The parent(s) or guardian(s) of a minor child will at all times be included in the decision-making process regarding the course of treatment for the patient.

POLICY AND PROCEDURE:

Advance Directives are documents allowing patients to give direction about future medical care. There are two types:

Living Will- Written instructions explaining wishes regarding health care should the patient have a terminal condition.

Durable Power of Attorney- Written document naming a person to make decisions for the patient if the patient becomes unable to do so.

Patients with Advance Directives are responsible for informing their physicians of their wishes.

If the patient and/or family makes it known that an Advance Directive exists, staff and/or anesthesia will explain our policy is **NOT TO HONOR** Advance Directives. The patient is then given the option to have his/her procedure done elsewhere if they wish. **Patient has an Advance Directive?**
YES **NO**

If the patient expresses wishes in formulating an Advanced Directive, the Surgery center will provide official state advance directive forms downloadable from the Illinois Department of Public Health website., the patient will then be referred to their primary care provider for assistance.

This information was prepared by the Illinois State Department of Public Health as an overview of advanced directives. Information is available regarding Advance Directives at www.idph.state.il.us/public/books/advin.htm.

The Exercise of Patient’s Rights Provides For:

Exercise of his/her rights by a patient while receiving care of treatment in the facility without coercion,

discrimination or retaliation.

Having a surrogate (parent, legal guardian, person with medical power of attorney) exercise the patient’s rights when the patient is incapable of doing so without coercion, discrimination or retaliation.

The process to inform each patient or when appropriate the patient’s representative (as allowed under state law) of the patient’s rights in advance of furnishing or discontinuing patient care whenever possible.

The right to be fully informed in advance of care or treatment and to participate in the development and implementation of his/her plan of care.

The right to make informed decisions regarding his/her care, be informed of his/her health status, and be involved in care planning and treatment and being able to request or refuse treatment (this right must not be construed as a mechanism to demand the provisions of treatment or services deemed medically unnecessary or inappropriate).

The right to consent or refuse treatment after being adequately informed of the benefits and risks of, and alternatives to treatment.

You have the right to expect reasonable continuity of care. The right to know in advance what appointment times and physicians are available. You have the right to expect that the center will provide a mechanism so you are informed by your physician, or delegate of your physician, of your continuing healthcare requirements following discharge.

The right to have family members or a representative of his/her choice and his/her own physician notified promptly of his/her admission to a hospital.

The right to personal privacy.

The right to receive care in a safe setting. You have the right to considerate and respectful care.

The right to be free from all forms of abuse or harassment.

FINANCIAL RESPONSIBILITY

You may receive bills from several different providers for the care rendered to you today. The physician performing the procedure, Ambulatory Surgery Center (ASC), Anesthesia and a laboratory- if a specimen is obtained during the procedure.

Financial Agreement:

If you have insurance we will help you receive maximum benefits by filing for you. However, we will expect payment of the co-pays, coinsurance and deductible at the time of the service.

Assignment of insurance Benefits, Medicare/Other Insurance:

I hereby assign benefits to be paid, on my behalf, to the ASC that renders service to me. I understand and agree to be financially responsible for the charges not paid within a reasonable time through my insurance and/or another payer.

Release of Information:

I authorize the ASC to release all or part of my medical resources when required for the submission of any insurance claims for payment to the Center for the Medicare Services and their agents, my insurance company(s) or to my employer (for worker’s compensation claim).

Disclosure of Ownership:

A physician performing the procedure may have an ownership interest in this facility. A schedule of typical fees for services provided by this facility is available upon my request. These procedures are performed at hospitals and other outpatient facilities in this community. I have the right to choose where to receive services, including a facility where my physician does or does not have an ownership interest. I have chosen to be treated at this facility.

Patient: _____

Physician: _____

Procedure _____

I have read and understand my rights and responsibilities, Advance Directives and Financial Information in advanced and prior to my procedure as a patient at this surgery center and agree to all contain herein.

_____/_____/_____
Patients’s Signature Dates
Amended 3/31/10