PATIENT'S RIGHTS AND RESPONSIBILITIES

The Western Maryland Surgicenter is owned and operated by Howard R. Strauss, D.D.S.

The services of the ambulatory surgery center shall be available to all individuals regardless of race, color, creed, sex, religion, or national origin. All patients and their families shall be treated with respect, consideration, and dignity.

All patients are encouraged to actively participate in their medical and surgical treatment plan. Patients shall be provided with all relevant information concerning their diagnosis, treatment, and prognosis. When necessary or appropriate, this information will be available and discussed with an appropriate patient-designated or legally authorized patient representative. Information contained in medical records is considered confidential. Patients will be allowed to review and obtain copies of their medical records promptly upon request. A patient may request that the surgeon amend a record that is not accurate, relevant, or complete. The surgeon will have the sole discretion as to whether to make the requested amendment. If the surgeon does not amend the record, the patient may add a brief statement to the record. Whenever the record is disclosed or transferred, any such statement must be included.

No experimental procedures are performed in the surgery center.

Representatives from the ambulatory surgery center will ensure the following information has been made available to each patient:

RIGHTS

1. Provisions regarding the normal hours of operation of the ambulatory surgery facility, specific directions to address, and after-hours emergency concerns or issues which may arise. We will make every effort to see you near the time of your appointment. (Be aware that emergencies do occur, so you could experience a delay in being seen. If this in an inconvenience, you will be given the option of rescheduling your appointment.)

2. The patient, or the patient's representative, shall receive both written and oral discharge instructions providing guidance and appropriate telephone numbers to accomplish after-hours contact. As a patient at this office/Surgicenter, you can expect that your reports of pain will be believed and you will be given information concerning your pain and pain relief measure by a concerned staff member who will respond quickly to your reports of pain with effective pain management techniques.

3. The patient shall receive clear and concise information regarding the procedures planned, the anticipated outcome or results, and the consequences of refusing treatment or not complying with the established treatment plan. There shall be a written, signed, and witnessed surgical consent obtained prior to each surgical or diagnostic procedure performed in the facility.

4. The ambulatory surgery center shall not provide treatment to unemancipated minors not accompanied by an adult. The minor's parent, legal guardian, or properly designated and pre-authorized representative must be present at the facility prior to an unemancipated minor receiving treatment in the facility. A pre-authorized patient representative must be designated in writing by the minor's parent or legal guardian prior to the date of surgery.

5. We will respect your decision concerning DNR orders or a living will. Be aware that your surgery here is most likely elective and the administration of anesthetic agents and some medications may cause variations in your vital signs that we can correct. We will, therefore, ask that you consider rescinding any DNR requests while receiving care in our facility. Any questions regarding this request should be directed to Dr. Strauss or the Clinical Supervisor.

6. Each patient shall receive information regarding the fees associated with the use of the facility. The patient shall be advised of the ambulatory surgery center's policy regarding the processing of insurance claims, the payment of patient co-pays and deductibles, and the policy concerning balance billing for services rendered.

7. All information provided to the patient concerning the ambulatory surgery center shall accurately reflect the facility's competence, capabilities, licensure, certification, and accreditation.

RESPONSIBILITIES

1. The patient shall be on time for appointments. If an appointment needs to be changed or cancelled, as much notice as possible should be given.

2. The patient shall follow instructions. If instructions are not clear or the patient or patient's representative has questions, they will notify the office. As a patient at our office/Surgicenter, we expect that you will ask your doctor or nurse what to expect regarding pain and pain management, discuss your relief options with your doctor or nurse, and work with them to develop a pain management plan. You should ask for pain relief when the pain first begins and help your provider and nurses assess your pain and to answer any questions you have concerning taking pain medications.

3. The patient or patient's representative shall read consent forms and have all questions clarified before signing the forms.

4. If the patient is a minor, the parent or guardian is to remain in the ambulatory surgical center while the patient is undergoing treatment. The parent or guardian shall provide care and guidance to the minor patient concerning post-operative and follow-up care.

5. The patient shall provide information concerning DNR orders or living wills to be included with other medical information.

6. The patient shall pay co-pays, deductibles, and the balance of bills according to the pre-arranged schedule of payment. If a payment cannot be made, the office manager must be notified before the payment is due.

7. The patient shall give accurate and up-to-date information concerning health history, medications, and insurance to the ambulatory surgical center. Any changes in health history, medication use, or insurance coverage will be conveyed to the center in a timely manner.

8. The patient or patient's representative is encouraged to ask questions and participate in decisions concerning health care, medications, and surgical procedures.

If you have concerns about your care, treatment, any of the services, or patient safety issues in our office you may contact us by mail or telephone. The following people will answer your questions and follow up on your concerns.

Leah Kidwell, Practice Administrator

Linda F. Stair, RN, Clinical Supervisor
301-777-1100
877-977-1101

Or you can submit your concern in writing to either Leah or Linda in care of this office.
Howard R. Strauss, D.D.S., P.A.
925 Bishop Walsh Road
Cumberland, MD 21502

Or contact the Office of the Medicare Beneficiary Ombudsman
http://www.medicare.gov/ombudsman/resources.asp
or the Office of health Care Quality, Program Manager of Ambulatory Care Program Unit
800-492-6005

Or contact the Joint Commission
http://jointcommisssion.org

Howard R. Strauss D.D.S., P.A. / Western Maryland SurgiCenter
Notice of Privacy Practices for Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office. We will charge a small fee per page copied as allowed by law. We will need a reasonable amount of time to complete the copy work;
- Request a copy of this Notice of Privacy Practices every three years;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;

- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Linda Stair, RN, Clinical Supervisor and Privacy Officer, at 301-777-1100, in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Linda Stair, RN, Clinical Supervisor and Privacy Officer at 301-777-1100.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Linda Stair, RN, Clinical Supervisor and Privacy Officer. You may also file a complaint by mailing it or telephoning it to the **Secretary of Health and Human Services,** whose street address and telephone number is

The Public Ledger Building
150 S. Independence Mall West, Suite 372
Philadelphia, PA, 19106-3499
215-861-4441.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care, (surgery reminder, follow up call, yearly appointments), or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

Funeral Directors/Coroners
- We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

Disaster Relief
- We may use and disclose your protected health information to assist in disaster relief efforts.

For Specialized Governmental Functions
- We may disclose your protected health information for specialized government functions as authorized by law, such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Effective April 1, 2003

CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION
Howard R. Strauss, D.D.S., P.A./Western Maryland SurgiCenter

Patient's Name _____ Account number _____

Date of Birth _____ SSN _____

My personal health information is private and confidential. I understand that my doctor and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. I request payment of medical and dental benefits, including authorized Medicare, be made on my behalf for any covered services furnished me by Dr. Howard Strauss. I also authorize the release of any information needed to determine these benefits. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his staff would follow the agreed limits.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

____Home Telephone_____
____OK to leave a message with detailed information
____Leave message with callback number only

____Work Telephone_____
____OK to leave message with detailed information
____Leave message with callback number only

____Written Communication
____OK to mail to my home address
____OK to mail to my work/office address
____OK to fax to number indicated
____Other (fax, cell, etc)_____

_____

I allow you to give my clinical information to or answer questions from (*check all that apply*):

____Spouse_____
____Parent_____
____Child_____
____Other (specify):_____

I may cancel this consent at any time by doing one of the following:

1. Signing and dating a form that my doctor or his staff can give me called "Revocation of Consent for Use and Disclosure of health Care Information" or
2. Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his staff do not have to provide any further health care services to me.

My doctor has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies nad practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this agreement. My doctor may update this "Notice." If I ask, my doctor or his staff will provide me with the most current "Notice" and the current "Notice" will always be posted at my doctor's office.

My signature below indicates that I have been given the chance to review a current copy of my doctor's "Notice of Privacy Practices." My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment and healthcare operations.

_____

Patient (or legally authorized individual) signature Relationship to patient Date

_____

Witness Date

Howard R. Strauss, D.D.S., P.A.
Oral and Maxillofacial surgery

Account Number _____ Date _____

Name _____ Sex _____ Race _____
(Last) (First) (Middle)
Home Address _____ City _____ State _____ ZIP _____
Phone # (Home) _____ (Work) _____ (Cell) _____
SSN _____ email/FAX _____
Date of Birth _____ Age _____ Height _____ Weight _____ BMI _____
Marital Status: S M D W Spouse's name (if applicable) _____
Mother's Name _____ Father's Name _____
Notify in case of emergency (name/phone) _____
Patient's employer or full time or part time student _____
Primary Insurance _____
Occupation/School Name _____
Physician's Name _____ Dentist's Name _____

BP: **P:** **T:** **PAIN LEVEL:**

Circle **Yes**, **No**, **Family History**, or **Don't Know**

Asthma (Specify last attack) _____ Y N FH DK
Bronchitis _____ Y N FH DK
Chronic Lung Disease _____ Y N FH DK
Productive Cough _____ Y N FH DK
Recent cold/sinus infection _____ Y N FH DK
Sleep Apnea/CPAP mask _____ Y N FH DK
Shortness of Breath _____ Y N FH DK
Smoker _____ packs/day _____ Years _____ Y N FH DK
Smokeless tobacco ____ cans/wk _____ Years __ Y N FH DK
Tuberculosis _____ Y N FH DK
Kidney Disease _____ Y N FH DK
Liver Disease/Hepatitis _____ Y N FH DK
Anemia _____ Y N FH DK
Bleeding Tendency _____ Y N FH DK
Diabetes (how controlled) _____ Y N FH DK
Glaucoma _____ Y N FH DK
Thyroid Disease _____ Y N FH DK
Epilepsy (fainting, seizures) _____ Y N FH DK
Intellectual Disability _____ Y N FH DK

How do you best receive information (circle below)
Verbal Written Other _____

High/Low Blood Pressure _____ Y N FH DK
Heart Attack _____ Y N FH DK
Murmur/Valvular Disease _____ Y N FH DK
Pacemaker/artificial heart valve _____ Y N FH DK
Pre-medicate before dental procedures __ Y N FH DK
Rheumatic/Scarlet Fever _____ Y N FH DK
Artificial joints/orthopedic appliances ____ Y N FH DK
Angina _____ Y N FH DK
Heart Disease _____ Y N FH DK
Dysrhythmia _____ Y N FH DK
Congestive Heart Failure _____ Y N FH DK
Arthritis _____ Y N FH DK
TMJ Problems _____ Y N FH DK
Psychiatric Treatment _____ Y N FH DK
Cancer or Tumor _____ Y N FH DK
Radiation Treatment _____ Y N FH DK
History of alcohol or drug abuse _____ Y N FH DK
Venereal/STD's _____ Y N FH DK
HIV/AIDS _____ Y N FH DK
Chronic diseases/disorders not listed: _____
_____
_____

Please see reverse for additional information

Patient's Name _____ Account number _____

List all allergies including: medication, seasonal, environmental, and food (if medication allergy, list type of reaction)

_____

_____

_____

Have you ever had a bad reaction to local anesthesia? _____

List all medications including: over-the-counter, vitamins, herbs, fluoride, prescription, and birth control

Medication	Dose	Frequency	Last Dose	Medication	Dose	Frequency	Last Dose

_____

_____

_____

_____

_____

_____

_____

Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, Didronel, Aredia, Zometa, Boniva, or others)? _____

List hospitalizations and surgeries (including Dental surgeries/extractions)

_____

_____

_____

_____

List any anesthesia or surgical (including dental) complications experienced by you or any family members

_____

_____

_____

All patients:

Do you have a living will, advanced directive, or DNR order? _____

DPOA: _____ Copy in Chart: Yes No

Females only:

Last menstrual period? _____

Do you take Birth Control Pills? Yes No If yes, are you aware that antibiotics decrease effectiveness? _____

Pregnant/planning pregnancy? Yes No Due date _____ OB/GYN _____ Breastfeeding: Yes No

Age 13 and below:

Immunizations up to date? Yes No

Developmental History: _____ normal _____ abnormal (explain) _____

REASON FOR CONSULT: _____

PAN: _____

PA: _____

OTHER: _____

REFERRAL: _____

Accompanied by: _____ **Pt Rights and Resp: yes/refused** **Office Info book: yes/refused**

Information to patient: _____ Third molar _____ TMJ/mouth guard _____ Implant _____ Web Site _____ Other

Patient's (or Guardian's) Signature: _____ Date: _____

RN/Tec Signature: _____ Date: _____