



## **PRE-PROCEDURE CHECKLIST**

Please bring the following with you to Tri City Surgery Center:

- Medication Record
- Insurance Card
- Patient Financial Policy
- Protected Health Information Release
- Patient Satisfaction Survey – Email Request
- Photo Identification Card (i.e. State ID, Driver's License)
- Reading Glasses, if applicable
- Case for your dentures, glasses, contact lenses, or hearing aid, if applicable

If your child is having surgery:

- Favorite toy or blanket
- Formula or special food, if needed, for after surgery
- Diapers, if applicable
- Car Seat – Required for a child who is under five years of age by Arizona law

Tri City Surgery Center  
Patient Financial Policy

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**PLEASE READ: Tri City Surgery Center is proudly contracted with Blue Cross/Blue Shield, United Healthcare, Medicare, Bridgeway, and Phoenix Health Plan.**

If we are contracted with your insurance company, we will bill your insurance company and accept assignment of benefits. You will only be responsible for in-network co-insurance, co-payments and/or deductible.

If we are not contracted with your insurance company, we would request you sign this election of service form, and we will notify your insurance company that you have elected to have your procedure performed at our surgery center. We will make every effort to limit your financial responsibility to your in-network levels, by approximating your in-network co-insurance, co-payment, and/or deductible.

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**Notice and Election Form (Non-contracted Insurance ONLY):**

Tri City Surgery Center is not currently an “in network” provider for your health plan. While we attempt to resolve this issue, it is our policy to minimize the impact of this situation to our patients. Please contact our business office staff at (928) 445-1919 to discuss any questions you might have. We recommend that you consult your policy regarding your option to select out of network care.

**Election of out of network services:**

I understand that the surgery center where I wish to have my procedure performed is not currently in my health plan’s provider network. It has been recommended that I consult my policy regarding my out of network options and benefits. I wish to exercise **my option as a policy holder** to go out of my health plan’s provider network and have my procedure/treatment performed at Tri City Surgery Center, and I understand that the surgery center will make every effort to limit my financial responsibility to in-network levels.

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Signature of Patient/Responsible Party

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Date



**PROTECTED HEALTH INFORMATION RELEASE**

Who may receive information regarding your protected health information:  
(Please check all that apply)

Spouse  Name: \_\_\_\_\_  
Children  Name: \_\_\_\_\_  
 Name: \_\_\_\_\_  
Parent  Name: \_\_\_\_\_  
Guardian  Name: \_\_\_\_\_  
Other  Name: \_\_\_\_\_

May we leave messages regarding test results and/or appointments on your answering machine? Yes  No

I authorize the above list of persons who may receive my protected health information.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_



### Patient Satisfaction Survey – Email Request

Tri City Surgery Center is committed to providing the highest level of patient care. To achieve this objective we ask our patients or their caretaker to complete a brief patient satisfaction survey after their surgery.

To better serve you we have automated this process. Within 48 hours of your discharge from our facility, you will receive an email providing you with a link to complete our survey. The survey is performed online via a secure Internet connection to the independent company we have hired to gather survey results. Simply follow the instructions and give us your feedback. Patients who complete the survey online will be entered into a monthly drawing for a \$100 gift certificate to Amazon.com.

Please write legibly and provide the email address to forward the survey to in the boxes below:

If you do not have access to email or a computer, please let us know and we will provide you with a paper version of the survey to complete and return to us.

**Privacy Statement:** We are committed to protecting the confidentiality of our patient's information and identities and under no circumstances will your information be disclosed or used for marketing purposes.



Dear Patient,

Across the United States, approximately 2.3 million people become ill or have adverse side effects from medical therapy each year. Also, adverse drug events account for about 4.7% of US hospital admissions and contribute to an estimated \$3.8 million in costs per hospital each year.

Here at Tri City Surgery Center we take medication delivery very seriously. We believe that you, the patient, are a key member of the team that needs to be involved in enhancing accuracy of your treatment. In order to provide the highest quality safe care, we would like to document the most accurate and complete list of your current medications. This would include the name, dose and frequency of each medication you take. Since this information is detailed and may be difficult to remember, we ask you completed the enclosed Medication Reconciliation Form with all of your current medications (including multi-vitamins, herbals, special creams or lotions, laxatives, and any other over-the-counter remedies you take) before you come for your surgery.

When you arrive at the ASC, you will be asked to review the information we have regarding your medications in our medical record as well as the last dose taken.

When you leave our facility, we will give you an updated list of your medications for you to take to your next provider of care.

We are dedicated to providing the highest quality, safest care possible, and we appreciate your partnership to support us in achieving this goal. Please feel free to contact us at (928) 445 - 1919 with any questions.

Sincerely,

Melissa Hobbs, RN, MSN  
Administrator  
Tri City Surgery Center

**TRI CITY SURGERY CENTER  
HOME MEDICATION RECONCILIATION LIST**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please include all prescription, over-the-counter, vitamins and herbal/natural medications taken routinely prior to admission.**

Data Source:    Patient                       Family                       Pharmacy                       Medication Administration Record from another facility

Previous Surgery: \_\_\_\_\_

Allergies: \_\_\_\_\_

NAMES OF MEDICATIONS	DOSAGE	FREQUENCY (WHEN)	ROUTE (HOW)	INDICATION (WHY TAKING MED?)	LAST DOSE DATE/TIME	TO BE COMPLETED FOR DISCHARGE		
						RESUME	HOLD	DISCONTINUE
NEW MEDICATIONS	DOSAGE	FREQUENCY (WHEN)	LAST TAKEN	INDICATION (WHY TAKING MED?)	NEXT DOSE			

**POST-OP MEDICATIONS:**       No change; take all medications as listed on admission

Signature of RN reviewing list pre-operatively: \_\_\_\_\_

Signature of discharge RN: \_\_\_\_\_

**NOTE TO PATIENT:**      Please take this medication list to your next doctor's appointment. It is recommended that you bring a list of your current medications to each medical appointment.

# PRIVACY NOTICE

## Your Rights

Although your health record is the physical property of the healthcare practitioner or Facility that compiled it, the information belongs to you. You have the following rights regarding your health information:

**Right to Inspect and copy "your protected health information".** You may inspect and obtain a copy of your "protected health information" that is contained in a designated record set for as long as we maintain the "protected health information". A "designated record set" contains medical and billing records and any other records that your physician and the Facility use for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and "protected health information" that is subject to a law that prohibits access to "protected health information". Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your "protected health information" if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the first page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

**Right to Request amendments to your "protected health information".** If you feel the health information we have in your record is incorrect or incomplete, you may request an amendment of the information for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. In addition, we may deny your request if you ask us to amend information that:

- Was not created by this Facility;
- Is not part of the health information kept by or prepared for our Facility;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

**Right to Request a restriction on uses and disclosures of your "protected health information".** You may ask us not to use or disclose certain parts of your "protected health information" for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. For example, you could ask that (1) we not use or disclose information about a surgery you had or (2) that certain people not be told of certain information.

The facility is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the facility does agree to the requested restriction, we may not use or disclose your "protected health information" in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

# PRIVACY NOTICE

**Right to Request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or for an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

**Right to Receive an accounting.** You have the right to request an accounting of certain disclosures of your "protected health information" made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

**Right to obtain a paper copy of this notice.** Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

## Our Responsibilities

The Facility is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice that outlines our duties and privacy practices. We are required to:

- Keep your health information private and only disclose it when required to do so by law;
- Explain our legal duties and privacy practices in connection with your health records;
- Obey the rules found in the law and this notice;
- Accommodate your reasonable request for an alternative means of delivery or destination when sending your health information; and,
- Inform you when we are unable to agree to a requested restriction that you have given us.

We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future "protected health information" that we maintain. If the Facility changes its Notice, we will provide a copy of the revised Notice to current patients by sending a copy of the revised Notice via regular mail or through in-person contact at the next patient visit.

## Complaints

You have the right to express complaints to the Facility and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the Facility's Privacy Officer verbally or in writing, using the contact information provided on the first page of this Privacy Notice. We encourage you to express any concerns you may have regarding the privacy of your information.

**YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT**



## TRI CITY SURGERY CENTER

5430 Distinction Way / Prescott, AZ 86301  
Tel: 928-445-1919 / Fax: 928-445-5672

# PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION (ALSO CALLED "PROTECTED HEALTH INFORMATION" OR "PHI") MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Federal Law (the Health Insurance Portability and Accountability Act or "HIPAA") requires that health care providers inform patients of their rights regarding how "protected health information" (or "PHI") may be used and disclosed to complete treatment, payment, health care operations and other purposes that are permitted or required by law. This Privacy Notice describes our privacy practices as they relate to your "PHI" and as allowed by law. It also describes your rights in regard to accessing and controlling your "protected health information" in some cases. "Protected health information" means any written or verbal health information about you that includes individually identifiable data that can be used to identify the health information directly as yours. (For example, your social security number or birthdate with your name.) "PHI" refers to any and all information created or received by your health care providers that relates to your past, present or future physical or mental health care and treatment.

## Contact Person

The facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by calling or sending it to:

**Tri City Surgery Center**  
**5430 Distinction Way**  
**Prescott, AZ 86301**  
**Tel: 928-445-1919**

## Your Health Record and "protected health information"

Each time you receive medical care from a physician, surgical center, hospital, or other healthcare provider, a record of your visit is created. This record typically includes, but is not limited to, information such as your name, age, address, a history of your illness, injury or symptoms, any test results, x-rays and laboratory work, the treatment provided to you and treatment plans devised for your care, and notes on follow-up care to be performed. How your health care information may be used and what controls you may exercise over the use of your healthcare information is described in this Privacy Notice. Any changes that you wish to make must be put in writing and sent directly to the person listed above.



## TRI CITY SURGERY CENTER

5430 Distinction Way / Prescott, AZ 86301  
Tel: 928-445-1919 / Fax: 928-445-5672

# PRIVACY NOTICE

## ***Uses and Disclosures of "protected health information"***

The Facility may use your "protected health information" for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your "protected health information" may be used or disclosed only for these purposes unless the Facility has obtained your authorization for the use or disclosure or it is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your "protected health information" for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

**Treatment.** We may use and disclose your "protected health information" to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with anesthesia providers, nurses, technicians, lab personnel, radiology personnel, other facility staff involved in your care or a third party for treatment purposes. For example, we may disclose your "protected health information" to a laboratory to order pre-operative tests or to a pharmacy to fill a prescription. We may also disclose "protected health information" to health care providers who may be treating you or consulting with the Facility with respect to your care. In some cases, we may also disclose your "protected health information" to people outside the Facility who may be involved in your medical care while you are in the Facility, such as your personal or referring physician; or after you leave the Facility, such as other physicians, health care workers, family members, or others who care for you or who may provide services that are part of your care.

**Payment.** Your "protected health information" will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the surgery. We may also disclose "protected health information" to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your "protected health information" to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

**Operations.** We may use or disclose your "protected health information", as necessary, for our own health care operations to facilitate the function of the Facility and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

Other uses and disclosures for health care operations may include:

- Care management
- Protocol Development
- Training, accreditation, certification, licensing, credentialing or other related activities
- Activities related to improving health care or reducing health care costs
- Underwriting and other insurance related activities
- Medical review and auditing
- Business planning and/or development
- Internal grievance resolution

**Appointment Reminders.** We may use or disclose your "protected health information" to contact you, a family member or friend involved in your health care or as authorized by you as a reminder that you have an appointment for treatment or medical care at our facility. We may also leave a message on your answering machine / voicemail system or send you mail unless you tell us not to.

# PRIVACY NOTICE

**Treatment Alternatives.** We may use or disclose your "protected health information" to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health Related Benefits and Services.** We may use or disclose your "protected health information" to tell you about health related benefits or services that may be of interest to you.

**Individuals Involved in Your Care or Payment of Your Care.** We may use or disclose your "protected health information" to a friend or family member who is involved in your medical care and/or present during your medical care and treatment in our Facility. We may also give information to someone assisting you in the payment for your care. We may also tell your family or friends that you are in the Facility at the time of your care, or that information may be communicated to an entity assisting in a disaster relief effort in order to communicate your condition status and location to your family. If you want any of this information restricted you must communicate that to us using the appropriate procedure which can be explained to you by Facility staff.

**Research.** Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one procedure to those who received another procedure for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with the patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process, but we may, however, disclose health information about you to people preparing to conduct a research project, for example, to help them look for patients with specific health needs, so long as the health information they review does not leave the hospital. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Facility.

**As Required By Law.** We will disclose health information about you when required to do so by federal, state, or local law. This may include reporting of communicable diseases, wounds, abuse, disease/trauma registries, health oversight matters and other public policy requirements. We may be required to report this information without your permission.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

**To Conduct Health Oversight Activities.** We may disclose your "protected health information" to a health oversight agency (i.e. State Health Department) for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

# PRIVACY NOTICE

**In Connection With Judicial And Administrative Proceedings.** We may disclose your "protected health information" in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your "protected health information" in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

**For Law Enforcement Purposes.** We may disclose your "protected health information" to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

**To Coroners, Funeral Directors, and for Organ Donation.** We may disclose "protected health information" to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose "protected health information" to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. "Protected health information" may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**For Specified Government Functions.** In certain circumstances, federal regulations authorize the facility to use or disclose your "protected health information" to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

**For Worker's Compensation.** The Facility may release your health information to comply with worker's compensation laws or similar programs. Many HIPAA Privacy provisions do not apply to health care delivered under Workers' Compensation coverage or to the health information generated as part of that care and treatment.

**Employers.** We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

**Uses and Disclosures which you Authorize.** Other than as stated above, we will not disclose your health information without your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon your past authorization and have already released your "personal health information".



## **A Tradition of Caring**

### **Designed With You In Mind**

More doctors are referring their patients who require elective procedures to an ambulatory surgery center simply because it is a high quality, cost-effective alternative for patient care. You can now experience high quality care in a relaxed, personal atmosphere. Thanks to modern technology and the most recent medical advances, the finest in operative healthcare is now available to you and your family.

### **The Benefits**

There are a number of benefits to using Tri City Surgery Center:

- Surgery is performed by your own physician at our facility, assuring you the same quality of care to which you are accustomed.
- Realizing that each case is unique, we provide close, personal attention at all times.
- The patient's family will find comfort in our center's relaxed, informal setting.
- Board certified specialists and state-of-the-art technology ensure the safety and well-being of all our patients.
- Surgery may be more economical due to the absence of overhead costs.
- The latest modern imaging and procedural equipment in both the operating and recovery rooms help our doctors provide top-quality care.
- Simplified admitting and discharge procedures provide added convenience for the patient.

### **Established History**

Tri City Surgery Center opened its doors to the public in September 2006. Since that time, we have quickly become the destination of choice for many people in northern Arizona requiring surgical care. We perform thousands of procedures every year, providing safety, comfort and convenience available only in an Ambulatory Surgical Center. Our highly qualified nursing and technical staff were chosen for their vast experience as well as for their compassion and concern for your care. Rest assured that you are in very capable hands. We are committed to providing you with the finest care available, while maintaining the comfort and individual attention that you deserve. Your experience here at Tri City Surgery Center is very important to us. If you have any questions or concerns, please contact us anytime.



## Quick Information

### **Our Address:**

Tri City Surgery Center  
5430 Distinction Way  
Prescott, Arizona 86301

(928) 445-1919

### **Extensions:**

2101	Reception
2109	Billing Department
2108	Scheduling
2113	Pre-Op
2114	Recovery
2105	Medical Records
2104	Administration

### **Driving Directions:**

#### **West bound on HWY 89A**

Exit Larry Caldwell ramp, proceed South (Left) over the freeway on Larry Caldwell Dr., turn West (Right) on Assurance Way, turn South (Left) on Distinction Way and the Center is on the West (Right) side.

#### **East bound on Hwy89A**

Exit on Larry Caldwell ramp, turn South (Right) on Larry Caldwell Dr., turn West (Right) on Assurance Way, then turn South (Left) on Distinction way and the Center is on the West (Right) side.

### **Website:**

Please visit our website, where you can download forms and get additional information.

[www.tricitysurgerycenter.com](http://www.tricitysurgerycenter.com)



### **IMPORTANT PRE-PROCEDURE INSTRUCTIONS**

- ❖ Arrive at Tri City Surgery Center at least 1 hour prior to your scheduled surgery time.
- ❖ Bring your insurance or Medicare card, any secondary insurance information, and a photo identification card with you.
- ❖ Bring your reading glasses with you. You will need to sign paperwork.
- ❖ You will not be allowed to drive yourself home. Please make arrangements for someone to drive you from the surgical center.
- ❖ Be sure to shower or bathe the evening before or the morning of your surgery.
- ❖ Wear comfortable clothing that will accommodate a dressing on your surgical site. You will be required to change into a hospital gown prior to your procedure, and change back into your own clothes when you leave.
- ❖ Please remove all jewelry, including body piercings, prior to arriving to the surgery center.
- ❖ Please remove contacts prior to arriving to the surgery center, if applicable.
- ❖ Do not wear makeup or fingernail polish the day of surgery. If you are having hip, leg, knee, ankle, or foot surgery, do not wear any toenail polish.
- ❖ Take medicines for your heart, blood pressure, lungs, and/or antibiotics on schedule with a small sip of water. Any other medicines should be held until after your procedure unless specifically instructed otherwise by your surgeon or anesthesiologist. If you use an inhaler, please bring it with you.
- ❖ If you feel you could be pregnant, please inform your surgeon and/or a Tri City Surgery Center employee as soon as possible.
- ❖ Unless instructed otherwise by your physician office, do NOT eat or drink anything after midnight the night before your surgery. You may brush your teeth and rinse your mouth. It is very important that you have an empty stomach prior to receiving anesthesia. This is for your safety. Nothing should be taken by mouth for at least 8 hours before your procedure including candy, gum, etc. Also, please eat a light meal the evening before your surgery.
- ❖ Do not shave the surgery site yourself before surgery. Nicks, cuts, scratches and rashes may cause your surgery to be cancelled.
- ❖ Notify your doctor if you develop a cold, sore throat, cough, fever, or illness prior to surgery.
- ❖ Do NOT smoke the morning prior to your surgery.
- ❖ Do NOT bring any valuables with you to the surgical center – we cannot be responsible for these items.
- ❖ Please contact the surgery center if you have any questions, comments, or concerns. A nurse will attempt to contact you at home prior to your surgery. If you will not be available or prefer not to be contacted by our office, please call us at 445-1919 between 8:00am and 5:00pm Monday through Friday.



## **TRI CITY SURGERY CENTER**

### **NOTICE TO PATIENTS: Physician Financial Ownership**

We are required by Federal law to notify you that physicians hold financial interests or ownership in this ASC. We are required by 42 C.F.R. § 416.50 to disclose this financial interest or ownership in writing and in advance of the date of the procedure you are scheduled to receive at the facility. A list of physicians who have a financial interest in this ASC is listed below:

1. Mark Fetter, M.D.
2. Eric Nelson, M.D.
3. Kent Peterson, DPM
4. Richard Pleva, M.D.
5. Scott Price, M.D.
6. Brian Schilperoort, M.D.
7. Alan Walters, M.D.
8. Angela Wang, M.D.

Please be advised that you may choose any other organization for the purpose of obtaining the services ordered or requested.

### **NOTICE TO PATIENTS: Policy for Advanced Directives**

Advance directive is a general term that refers to your oral or written instructions about your future medical care in the event that you become unable to communicate those instructions. As a provider of outpatient services, it is the policy of Tri City Surgery Center that Advance Directives will NOT be honored. Tri City Surgery Center will provide full resuscitative service for any patient requiring emergency life saving/support. Cancellation of your procedure due to the facility's policy regarding Advance Directives must be discussed with your physician prior to the date of service.

If you would like information on developing Advanced Directives, the following website can assist you and includes a description of the State's health and safety laws:

<http://www.uslivingwillregistry.com/forms/shtm>

Additionally, upon request, we will provide you with official State advance directive forms.

**TRI CITY SURGERY CENTER, LLC**  
**CONSENT FOR TREATMENT AND RENDERING OF OTHER MEDICAL SERVICES, INCLUDING CONSENT FOR**  
**TRANSFUSION, BLOOD TESTING, FINANCIAL AGREEMENT, AND RELEASE OF RECORD(S)**

We are required to obtain your consent for your planned surgery/medical procedure and anesthesia. What you are being asked to sign is a confirmation that your doctor has discussed the nature, purpose, risks, benefits, and alternative treatment available in regard to your surgery/medical procedure and anesthesia care. Except in cases of emergency, surgery/medical procedures and anesthesia are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent to or refuse any proposed surgery or medical procedure at any time prior to its performance. By reading and signing this document, you agree to the following:

**Risks and Results Not Guaranteed:** I understand that surgeries, medical procedures and operations may involve risks, unsuccessful results, serious complications, injury, or even death, from both known and unknown causes, and no warranty or guarantee of success has been made regarding results or cures.

**Operation:** My doctor has explained the nature of the surgery/medical procedure, the risks and benefits, possible complications, expected benefits or effects, and alternative treatment available to me and has answered all the questions that I asked. The information has been presented in a clear manner that I understand. Except in cases of emergency, operations or procedures will not be performed until I have had the opportunity to receive this information and have given my consent. I authorize my doctor to perform any other incidental/minor surgery or medical procedure that, in his/her judgment is medically necessary for my well-being. In some cases, my doctor will not be able to identify ahead of time just what the additional surgery/medical procedure might be. I understand this. If there are surgeries or procedures that I do not want performed, I have informed my doctor. I agree that the surgery/medical procedure(s) on the Authorization for Operative Invasive Procedure are correct, and the correct body part is noted (if applicable).

**Additional Associates, Assistants, or Other Healthcare Providers/Observers:** My physician may also assign or request additional assistance from anesthesiologists, nurse anesthetists (CRNA's), licensed medical residents in training or others who perform specialized medical care and treatment. I understand that the persons who perform these specialized medical services, such as anesthesia, radiology, or pathology, are independent contractors and are not agents, servants, or employees of the Facility or my doctor. Since they are independent contractors the Facility is not responsible or liable for acts or omissions. In addition, I authorize the presence of approved observers for my surgery/medical procedure. This includes medical/nursing students; medical school residents/interns; medical company equipment specialists; and other healthcare students. My doctor has explained their role and involvement in my care and treatment. I understand that I have a right to privacy and that I do not have to agree to their presence during my surgery/medical procedure.

**Facility Personnel and Equipment:** I understand that the Facility maintains personnel and equipment to assist my doctor with surgical operations and other special diagnostic or therapeutic procedures. I consent to use the Facility personnel and equipment for my care.

**Tissue:** I authorize my physician and/or the pathologist to use his/her discretion in disposing of any member, organ, or other tissue removed from my body during the surgery/medical procedure.

**Videotapes/Photographs:** I authorize the Facility staff or my doctor to photograph or videotape my surgery/medical procedure and use the prints, negatives, or videotapes for purposes related to my healthcare, professional activities or medical education. My identity will not be shown, and the photos, negatives and videotapes will be the property of the physician or the Facility.

**Emergency Treatment:** I authorize the Facility and my physician to transfer me to another health care facility if medically necessary for my care. I also consent to the release of my medical records to the facility and to other doctors who will continue my care.

**Transfusion of Blood or Blood Products:** In the event of a true life-threatening medical emergency, I authorize the transfusion of blood or blood products.

**Accidental Exposure:** In the very rare event that a Facility employee or health professional has accidental exposure to my blood or other body fluids (for example, they are stuck by a needle), I authorize the Facility to draw blood for testing for the presence of HIV/AIDS or hepatitis. I know I will not be charged for this testing. Test results will be used, if tests show presence of these illnesses, to offer medical care to the employees or healthcare professionals and to protect my health and the health of my family. All results will be forwarded to my personal physician for confidential medical follow-up and treatment if needed.

**TRI CITY SURGERY CENTER, LLC**  
**CONSENT FOR TREATMENT AND RENDERING OF OTHER MEDICAL SERVICES, INCLUDING CONSENT FOR TRANSFUSION, BLOOD TESTING, FINANCIAL AGREEMENT, AND RELEASE OF RECORD(S)**

**Release of Information:** I agree that the Facility may disclose my "protected health information" in compliance with HIPAA Privacy Provisions to any third party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers' compensation carriers, manufacturers required by FDA to track medical devices, or my employer. This includes appropriate release of and disclosure of my medical records in compliance with HIPAA to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

**Financial Agreement & Terms:** I agree to pay the facility in accordance with its regular rates and terms. Terms are net 30 days from date of bill unless otherwise indicated. Should collection become necessary, the responsible party agrees to pay any additional collection fees, and all legal fees of collection without suit, including attorney fees, court costs, and filing fees.

**Assignment of Insurance Benefits:** I authorize direct payment to the facility of any insurance benefit. I understand that I am responsible for any charges not paid by my insurer and I agree to pay any unpaid balances on my account no more than 30 days after the date of service.

**Medicare Certification, Release of Information, and Payment Request:** I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information 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.

**Notice of Policy Regarding Advance Directives:** I understand that there are several types of advance directives; the two most common forms are living wills and durable power of attorney designation. I understand that in the ambulatory care setting, if I suffer a cardiac or respiratory arrest or other life-threatening situation, signing this document grants consent for resuscitation and transfer to a higher level of care. Therefore in accordance with Federal law, the facility is notifying you that it will NOT HONOR previously signed advanced directives. If this is not acceptable to you, you must address this issue with your physician and anesthesiologist/anesthetist. You were informed of our policy regarding Advance Directives both in writing and verbally prior to the date of service and understand our policy. **Do you have an advanced directive?** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **INITIALS:** \_\_\_\_\_

**Disclosure of Ownership:** The physician who refers you to Tri City Surgery Center may have an ownership interest in this facility. You are free to choose another facility in which to receive services. You were informed of this relationship both in writing and verbally prior to the date of service. **INITIALS:** \_\_\_\_\_

**HIPAA Privacy Notice:** I acknowledge that I have received the Facility's HIPAA Privacy Notice and have had the opportunity to review its content. **INITIALS:** \_\_\_\_\_

**Patient Bill of Rights:** I acknowledge that I have received my Patient Rights in writing and that my Patient Rights were verbally explained to me prior to the date of service. **INITIALS:** \_\_\_\_\_

**Patient Statement of Responsibilities:** I acknowledge that I have received my Patient Statement of Responsibilities and have had the opportunity to review its content. **INITIALS:** \_\_\_\_\_

My signature below certifies (1) that I have read and understood the information provided in this form, and am the patient or am duly authorized to execute it and accept its terms; (2) that the surgery medical procedure has been adequately explained to me by my doctor; (3) that I have had a chance to ask questions; (4) that I have received all of the information I need concerning the surgery/medical procedure; (5) that I accept any substantial and significant risks of the procedure; and (6) that I authorize and consent to the performance of the surgery/medical procedure.

\_\_\_\_\_  
Patient/Parent/Guardian/or Conservator Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by anyone other than the patient – please indicate relation

\_\_\_\_\_  
Time

\_\_\_\_\_  
Witness



## **Tri City Surgery Center Patient Bill of Rights**

This Facility adopts and affirms as policy the following rights of patient/clients who receive services from our facility. The facility will provide the patient or the patient's representative verbal and written notice of such rights in advance of the date of the procedure in accordance with 42 C.F.R. § 416.50, and these patient rights will be posted within the facility in the facility's waiting room(s).

The patient rights are as follows:

- Treatment without discrimination as to age, race, color, religion, sex, national origin, political belief, or handicap. It is our intention to treat each patient as a unique individual in a manner that recognizes their basic human rights.
- Considerate and respectful care including consideration of psychosocial, spiritual, and cultural variables that influence the perceptions of illness.
- Receive, upon request, the names of physicians directly participating in your care and of all personnel participating in your care.
- Obtain from the person responsible for your health care complete and current information concerning your diagnosis, treatment, and expected outlook in terms you can be reasonably expected to understand. When it is not medically advisable to give such information to you, the information shall be made available to an appropriate person in your behalf.
- Receive information necessary to give informed consent prior to the start of any procedure and/or treatment, except for emergency situations. This information shall include as a minimum an explanation of the specific procedure or treatment itself, its value and significant risks, and an explanation of other appropriate treatment methods, if any.
- The patient may elect to refuse treatment. In this event, the patient must be informed of the medical consequences of this action. In the case of a patient who is mentally incapable of making a rational decision, approval will be obtained from the guardian, next-of-kin, or other person legally entitled to give such approval. The facility will make every effort to inform the patient of alternative facilities for treatment if we are unable to provide the necessary treatment.
- The facility will provide the patient or patient representative with the facilities policies and description of the State health and safety laws on advance directives, and upon request, refer you to resources for general information on how to formulate an advance directive, including where to obtain the official State advance directive form, and appointing a surrogate to make health care decisions on your behalf, to the extent permitted by law. Access to health care at this facility will not be conditioned upon the existence of an advance directive.
- Privacy to the extent consistent with adequate medical care. Case discussions, consultation, examination and treatment are confidential and should be conducted discreetly.
- Privacy and confidentiality of all records pertaining to your treatment, except as otherwise provided by law or third party payment contract.
- A reasonable response to your request for services customarily rendered by the facility, and consistent with your treatment.
- Expect reasonable continuity of care and to be informed, by the person responsible for your health care, of possible continuing health care requirements following discharge, if any.
- The identity, upon request, of all health care personnel and health care institutions authorized to assist in your treatment.
- Refuse to participate in research or be advised if your personal physician and/or facility proposes to engage in or perform human experimentation affecting his/her care or treatment.

## Tri City Surgery Center Patient Bill of Rights

Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services

- Upon patient request, examine and receive a detailed explanation of your bill including an itemized bill for services received, regardless of sources of payment.
- Know the facility's rules and regulations that apply to your conduct as a patient.
- Be advised of the facility grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels the determined discharge date is premature. Notification of the grievance process includes: who 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 contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.
- Complaint or criticisms will not serve to compromise future access to care at this facility. Staff will gladly advise you of procedures for registering complaints or to voice grievances including but not limited to grievances regarding treatment or care that is (or fails to be) furnished.
- Access and copy information in the medical record at any time during or after the course of treatment. If patient is incompetent, the record will be made available to his/her guardian.
- Expect to be cared for in a safe setting regarding: patient environmental safety, infection control, security and freedom from abuse or harassment.
- Receive care, free of restraints unless medically reasonable issues have been accessed and pose a greater health risk without restraints.
- Participate in the development, implementation and revision of his/her care plan.

### Complaints

- Complaints may be directed to the following Facility Contact(s):

<b>Melissa Hobbs, Administrator</b> 5430 Distinction Way Prescott, AZ 86301 (928) 445-3704	<b>Laura Smith, Business Office Manager</b> 5430 Distinction Way Prescott, AZ 86301 (928) 445-5620
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- Complaints may be directed to the following State Agency:

<b>Arizona Department of Health Services</b> 150 North 18th Avenue Phoenix, Arizona 85007 (602) 542-1025
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- Web site for the Medicare Beneficiary Ombudsman: [www.medicare.gov](http://www.medicare.gov) or 1-800-633-4227 or [www.cms.hhs.gov/center/ombudsman](http://www.cms.hhs.gov/center/ombudsman)



## Understanding Your Charges

### **Types of Bills**

Here is a brief explanation of the possible charges which you may receive following a surgery:

#### Surgery Center

This fee is for the staff and equipment we provide for your safe and successful experience here. Questions and payments regarding your surgery center billing should be addressed to our office.

#### Physician

Your procedure will be performed by a surgeon. Since this physician is not an employee of our surgical center, he/she will bill you separately for your procedure. The physician's bill, along with any questions pertaining to it must be addressed to their office.

#### Anesthesia

If you receive anesthesia from an anesthesiologist or CRNA during your procedure, you will receive a separate bill for these services as well. You must address all questions and send all payments to that respective billing group or physician.

#### Other Charges

Depending on several factors related to your particular procedure, you may receive other charges. These may include Durable Medical Equipment (such as crutches, braces, etc.), lab fees or other services not performed at Tri City Surgery Center. Questions for these must be directed to the respective company or provider.



## **Billing**

### **Your Insurance**

As a courtesy to our patients, we will bill your insurance company when provided with the necessary information. Please realize that your policy is a contract between you and the insurance company. We are not a party to that contract. Any required co-payments, deductibles or non-covered services are beyond our control, and are your responsibility.

Tri City Surgery Center is proudly contracted with Blue Cross/Blue Shield, Medicare, Bridgeway, and Phoenix Health Plan. However, we will bill most major insurances. Your insurance company may or may not pay all charges. Contact your employer or insurance company if you have questions about your coverage. Also, you may contact our billing department with questions regarding our fees, or the level of benefits provided from your insurance and your subsequent responsibility.

### **Patient Statement**

All charges are your responsibility from the date services are rendered. After your insurance has remitted payment to us, you may be responsible for any balance unpaid by your insurance company. For your convenience, we accept cash, personal checks, bank debit cards, Care Credit, and most major credit cards.



## Your Responsibilities

So that you may contribute effectively to your health care, you have, as a patient, the following responsibilities:

1. To provide the center with a copy of any advance directives, Living Will, or Healthcare Power of Attorney you may have executed.
2. To be honest and as accurate as possible when asked for information about your medical history and everything that happens to you as a patient, including present and past illnesses, hospitalizations, medications, allergies, and “NPO” status.
3. To make every attempt to understand the implications of my procedures, including risks of refusing treatment.
4. To participate actively in agreed upon decisions regarding your health care.
5. To notify your doctor or nurse if you have any concerns about your care and if you notice, or think you notice any changes in your health.
6. To ask promptly for a clarification if you do not understand what is asked of you, or why it is asked.
7. To let your doctor or nurse know if you are concerned about a treatment, or if you feel you cannot or will not follow certain treatment plan and to be responsible for the consequences if you refuse treatment or do not follow instructions.
8. To examine your bill and ask any questions you may have regarding the charges or methods of payments, and for assuring that the financial obligations of your health care are fulfilled as promptly as possible and that updated insurance information has been provided.
9. To follow Center rules and regulations affecting patient care and conduct, to be considerate of other patients and center staff, and to assist in controlling the noise and the number of your visitors.
10. Keeping appointments or notifying the health care provider when unable to do so.



## Medication Side Effect Information

Chances are that during your stay with us, you will receive a variety of medications that help to make your procedure and recovery successful. In our commitment to quality care, it is our obligation to inform you about some of the medications you will receive during your stay, as well as their possible side effects. It is important that you understand that the effects of these drugs may last up to 24 hours following their administration. During such time, you should not operate a vehicle or other machinery, sign important papers, or decide legal matters. You should not drink any alcoholic beverages.

<b>Drug Type/Name</b>	<b>Uses</b>	<b>Possible Side Effects</b>
<b>Sedatives:</b> Propofol, Versed, Ketamine, Valium, Benadryl	Sedation and maintenance of anesthesia	Light headedness, sedation, forgetfulness, drowsiness, anxiety, and dizziness
<b>Anesthesia Gases:</b> Sevoflurane, Forane	To maintain sleep during surgery	Light headedness, may have some difficulty urinating, sedation
<b>Antibiotics:</b> Cipro, Ancef, Ampicillin, Rocephin, Clindamycin, Levaquin, Gentamycin, Vancomycin	To prevent infection	You will probably experience no side effects. Rarely you may experience hives, rash, or itching
<b>Antinausea Medicine:</b> Reglan, Zofran, Pepcid, Phenergan, Compazine	To help prevent and treat nausea and vomiting	Dry mouth, sedation, may have some difficulty urinating
<b>Pain Medicine/Opiates:</b> Demerol, Fentanyl, Morphine, Stadol	To help prevent and control pain	Sedation, light headedness, nausea, and rarely confusion
<b>Pain Medicine/Non-Opiates:</b> Toradol	To help prevent and control pain	You will probably experience no side effects
<b>Pain Medicines/By Mouth:</b> Lortab, Darvocet, Percocet	To help prevent and control pain	Sedation, light headedness, nausea
<b>Heart Medicines:</b> Procardia, Labetalol, Hydralazine, Cardizem	To control heart rate and blood pressure	Dizziness, light headedness, sedation

**If you experience hives, rash, or itching – CALL YOUR DOCTOR!!**



## **Understanding the 2010 Ambulatory Care National Patient Safety Goals**

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

### **Identify Patient Correctly**

- For your safety, staff will ask you two questions that will ensure your identification so that they give the right medication or the right treatment to the right person. For example, the questions may include your name and date of birth.

### **Use Medicines Safely**

- All medications, syringes, cups, and basins are labeled so that no one gets confused over their content.
- Because of the effects of blood thinners, extra precautions will be taken when they are administered.

### **Prevent Infection**

- For everyone's safety, staff and patients should use the World Health Organization's or the Centers for Disease Control and Prevention's posted guidelines for hand hygiene.
- Continually updated standards of practice are in place to prevent infections to the body where surgery has been done.

### **Check Patient Medicines**

- Every patient is asked for a list of current medications to ensure compatibility with any new medications that may be prescribed during his or her visit.
- To ensure that you receive important medications, staff members will always inform your next provider about medications currently used to treat you.
- Before you are released, you may be given a list of medications to take at home (with an explanation of their purposes and side effects).
- When your doctor or nurse reviews the medications you should take upon discharge, be sure to let them know of any other medications that you may be taking at home (to ensure compatibility).