9800 Levin Road NW, Suite 102 - Silverdale WA 98383
Phone 360.692.2728 - Fax 360.692.6009
www.silverdaleasc.com

Welcome to the Surgery Center of Silverdale, LLC. We are a multi-specialty facility that opened in the Spring of 2007 with the goal of providing an outstanding outpatient surgical experience for patients and physicians in the West Sound region. We are accredited by the American Association of Ambulatory Health Care (AAAHC), certified by Medicare, and licensed by the WA State Department of Health.

The Surgery Center is a fragrance-free environment. We ask that you and your escorts/family members refrain from wearing scented perfumes or lotions.

Please read this entire brochure prior to the day of your surgical procedure. It contains information that is very important to your care as well as notifications and disclosures that we are required by law to provide.

Owner Information

The Surgery Center of Silverdale, LLC, is jointly owned by Kitsap Outpatient Surgery (70%) and Harrison Medical Center (30%). Kitsap Outpatient Surgery is comprised of: Paul Aufderheide, DPM; Jason Cheung, MD; Ty Chun, MD; Eric Cole, MD; Greg Duff, MD; Greg Fleischhauer, MD; Martha Leen, MD; Chris Merifield, MD; Deanne Nakamoto, MD; Adrian O'Malley, MD; Blake Reiter, MD; Todd Schneiderman, MD; David Spinak, MD; and Brad Watters, MD.

Patient Rights

As a patient at the Surgery Center of Silverdale, LLC, you have the right to:

1. Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
2. Information necessary to give informed consent prior to the start of your procedure, which will include your diagnosis, treatment, risks, and prognosis, to the degree known. When it is medically inadvisable to give such info directly to you, it will be made available to an appropriate person on your behalf.
3. Confidentiality of records and privacy of communications. Except as required by law, you have the right to approve or refuse the release of records.
4. The opportunity to participate in decisions involving your health care, unless contraindicated by concerns for your health.
5. Make decisions about medical care, including the right to accept or refuse treatment and to leave the facility even against the advice of your physician.
6. Refuse to participate in experimental research.
7. Receive written and verbal discharge instructions prior to leaving the facility.
8. Receive instructions for obtaining emergency care if needed after discharge.
9. Change your provider if other qualified providers are available.
10. Information concerning the center's policy regarding advanced directives.
11. Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.

12. Receive an itemized bill for all services and be informed of the fees and payment policies of the center.
13. Know the identity and professional status of individuals providing service to you.
14. Expect that marketing and/or advertising conducted by the Center is not misleading.
15. Report any comments concerning the quality of services provided to you during the time spent at the facility and receive fair follow-up on your comments within 30 days.

Patient Responsibilities

As a patient at the Surgery Center of Silverdale, LLC, you have the responsibility to:

1. Provide to the best of your knowledge, accurate and complete information about your present health status, past medical history and medications, including over the counter products as well as any allergies or sensitivities.
2. Follow the treatment plan recommended by your provider, including the instruction of nurses and other health professional as they carry out the physician's orders.
3. Provide an adult to transport you home after surgery and stay with you for 24 hours.
4. Indicate whether you clearly understand a contemplated course of action and what is expected of you.
5. Be liable for your actions if you refuse treatment, leave the facility against medical advice and/or do not follow your provider's instructions relating to your case.
6. Provide accurate information regarding your address, phone number, and insurance.
7. Accept personal financial responsibility for any charges not covered by your insurance.
8. Notify your provider and the center about advance directives including any living will, power of attorney or other directives that you desire us to know about.
9. Be respectful of health care providers and staff, as well as other patients.
10. Follow the facility policies and procedures affecting patient care and conduct.

To Report a Complaint

You may submit a complaint orally or in writing to the address below. The Center will respond within 30 days of receiving your complaint.

Surgery Center of Silverdale, LLC
ATTN: Administrator
9800 Levin Road, Suite 102
Silverdale, WA 98383

You also have the right to file a complaint with the WA State Department of Health:

PO Box 47857
Olympia WA 98504-7857
1-800-633-6828

If you are a Medicare beneficiary and need assistance, contact the Office of the Medicare Ombudsman via their web site at:

www.medicare.gov/Ombusman/activities.asp

Advance Directive Policy

An Advance Directive is a legal document that outlines your wishes in the event that you are unable to make medical decisions for yourself. It specifies the type of treatment you do and do not want, as well as who is authorized to make decisions on your behalf. The most common types of Advance Directives are a Living Will and a Durable Power of Attorney for Health Care.

Since procedures performed at the Surgery Center of Silverdale are not "high-risk" procedures – they are elective and of short duration – it is our policy that life-sustaining measures will be provided and you will be immediately transferred to the nearest or best-choice hospital. If you have executed an Advance Directive and provide us with a copy, it will be forwarded to the hospital along with your medical records in the event of a transfer. At the hospital, further treatment or withdrawal of treatment measures will be exercised in accordance with your

Advance Directive. If you disagree with this policy you should discuss it with your physician prior to your scheduled procedure.

If you do not have an Advance Directive and would like more information, our staff can provide you with a packet of information on Advance Directives in WA State.

General Instructions & What to Expect

- As early as possible before your surgery, fill out the pre-admission forms included in this packet or pre-register on our web site at www.silverdaleasc.com.

Pre-operative Phone Calls (does not apply to Pain Management patients)

- If you do not pre-register online, a nurse will call you 2-3 days before your procedure to gather important information about your medical history and current status including what medications you are taking . She will also give you pre-op instructions that you must follow.
- **The day before your procedure a nurse will call with your time of arrival**. Please note that due to changes in the schedule, your arrival time may change. We do our best to mitigate the impact of last minute changes but it is not always possible.

Before your Procedure -- Do's and Don'ts

- **Don't eat or drink anything after midnight the night before your surgery. This includes gum, water, cough drops, coffee, water, etc. You must not ingest anything or your procedure may be cancelled.**
- Don't drink alcohol for 24 hours before your procedure.
- Don't smoke after midnight the night before your procedure.
- Don't take medication containing aspirin for 24 hours before your procedure unless directed to do so by your physician.
- Failure to follow any of these instructions could result in your procedure being postponed or cancelled by the anesthesiologist.

Day of your Procedure – Do's and Don'ts

- **A responsible adult must drive you home. If you receive any type of anesthesia or sedation, you must also have an adult stay with you for 24 hours following your procedure. We will not administer anesthesia or sedation if you do not have a responsible adult companion.**
- Bring your insurance card and picture ID with you to the Surgery Center.
- Wear loose comfortable clothing that you can change easily.
- Don't wear jewelry or watches and remove all body piercings including tongue piercing.
- Don't use powders or lotions. Light makeup and deodorant are OK. You should not wear eye makeup if you are having an eye procedure.
- Don't wear your hair in a bun or a pony tail; it makes your anesthesia more difficult.
- If you are accompanying a minor child who is having a procedure, bring documentation of your guardianship if you are not a parent.
- Expect to spend about 30-60 minutes at the Center when your surgery is over. This is the average time needed for recovery and post-operative instructions; your needs may be different.
- If you are the parent or guardian of a patient who is a minor child, you must remain at the Center for the duration of the minor's care.

After your Procedure – Do's and Don'ts

- Don't drive or operate machinery, make any important decisions, or drink alcoholic beverages for 24 hours after your surgery.
- Be sure to follow post-operative instructions given to you at the Center.
- Be sure to have someone stay with you for 24 hours after your procedure. This is *required for your safety.*

- A nurse will call you the day after your surgery to make sure you're recovering comfortably and to answer any questions you might have.
- You will be given a Patient Satisfaction Survey after discharge; please fill it out and return it in the envelope provided. The survey can also be accessed online via our website at www.silverdaleasc.com.

Financial & Billing Policy

This information relates to services provided by the Surgery Center of Silverdale only. Your surgeon and anesthesia charges are separate.

INSURANCE CLAIMS: On your behalf, we will submit claims for our services with your primary and secondary insurance providers when you provide us with sufficient, accurate and up-to-date insurance information. If your insurance company does not submit payment, you are liable for your account balance and we will request immediate payment from you. We are not party to the contract between you and your insurance company, and payment of our charges is ultimately your responsibility.

PRIOR AUTHORIZATIONS AND PRECERTIFICATION: If your medical insurance plan requires a prior authorization or pre-certification, this should be obtained before your scheduled appointment. If we do not have the required pre-authorization, you will be liable for any amounts not paid.

ESTIMATE OF CHARGES AND PAYMENT ARRANGEMENTS: Prior to your procedure we will estimate your out-of-pocket charges based on information from your insurance company. The actual charge may vary dependent upon actual procedures performed. We request that 50% of your estimated patient responsibility be paid on the day of surgery and a minimum payment of 10% or $25 (whichever is more) is required. This fee is collected on or before your surgery date. If you incur a service that is not covered by your insurance company payment must be made in full at the time services are rendered. Payment plans may be available for the remainder or your balance and/or under special circumstances. All patient balances will incur a finance charge of no more than 1% per month or 12% per year.

DELINQUENT ACCOUNTS: If you do not comply with the payment policies of the Center, the Center will forward your account to a contracted collection agency for appropriate collections action. If this happens, there will be a $25 fee added to your balance.

PAYMENT: We accept cash, personal checks, and Visa or MasterCard in person, by mail, or over the phone.

Notice of Privacy Practices

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your

location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal official.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to submit a written request to our Privacy Officer.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Authorization for Disclosure: If you wish to authorize disclosure of your health information for reasons other than treatment, payment, or operations, you must do so in writing. The written authorization must include specific information about who is authorized to receive your health care information, and what information they are authorized to receive. (See form HIPAA Authorization for Disclosure).

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information without your authorization for reasons *other than* treatment, payment or healthcare operations.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

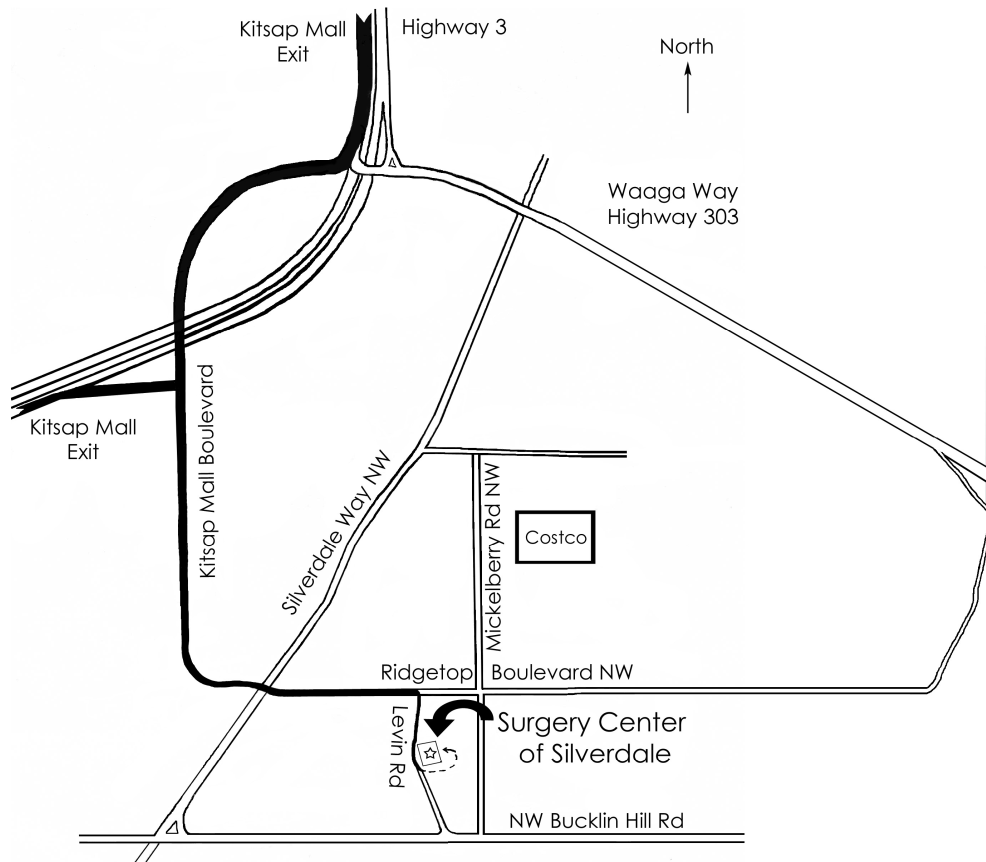
You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your written complaint should be directed to our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Map & Directions

9800 Levin Road NW, Suite 102 – Silverdale WA

From the North (Sequim & Poulsbo): Take Highway 3 South to the Kitsap Mall **Exit 45**. Turn right at the end of the ramp on to Kitsap Mall Boulevard. Continue straight through the intersection with Silverdale Way, to Levin Road NW. Turn right onto Levin Road. The Center is in the Clear Creek Medical Building which is the first building on the left side of Levin. The driveway is past the building on the left. Drive around to the parking lot and enter our facility through the building's front entrance.

From the South (Port Orchard & Bremerton): Take Highway 3 North to the Clear Creek Road/Kitsap Mall **Exit 45A**. Turn right at the end of the ramp on to Kitsap Mall Boulevard. Continue straight through the intersection with Silverdale Way, to Levin Road NW. Turn right onto Levin Road. The Center is in the Clear Creek Medical Building which is the first building on the left side of Levin. The driveway is past the building on the left. Drive around to the parking lot and enter our facility through the building's front entrance.



Allergy List

Please list any known allergies to medicines and your reactions

Allergy	Reaction	mild / severe / life threatening

Medication List

List all current medicines, supplements and herbs with doses

Medication	Dosage	Frequency/Date Stopped if applicable

Name:______________________________ Date of Birth:______________________

REGISTRATION FORM

Last Name:______________________________ First Name ____________________________MI:________

Address:____

(Street) (City) (State) (Zip)

Primary Phone: _______________ Other Phone: ________________ email: __________________________

Date of Birth:_______________ SSN:__________________ Employer:________________________________

In case of emergency, contact:

Name:____ Relationship:____________________________

Daytime Phone # ______________________________ Cell Phone #: ______________________________

Do you have any social, emotional or safety needs that we can be of assistance in addressing at this time?

No_____ Yes____

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT INFORMATION

I acknowledge that prior to my procedure at the Surgery Center of Silverdale, LLC, I was provided with the following important information relating to my services:

Owner Information
Patient Rights
Patient Responsibilities
Financial & Billing Policy
Advance Directives Policy
General Instructions / What to Expect
How to Report a Complaint
Notice of Privacy Practices

I have an Advance Directive: ☐ Yes ☐ No

I would like more information regarding how to complete an Advance Directive: ☐ Yes ☐ No

By my signature below, I acknowledge that:

- The information I have provided is true and accurate to the best of my knowledge.
- I have read and understand this information and my questions have been answered satisfactorily by the Surgery Center staff.
- I agree to comply by the terms of the Financial and Billing Policy.
- **I will have a responsible adult escort me from the surgery center and stay with me for 24 hours following my procedure. That adult's name is: ____________________________ and their relationship to me is ____.**

Signature: ____________________________________

Date: ____________________________________

IMPORTANT! COMPLETE INSURANCE INFORMATION ON BACK OF FORM

Responsible Party (if not patient):

Last Name:____________________ First Name ____________________MI:________

Address:____
(Street) (City) (State) (Zip)

Home Phone: ____________ Cell Phone:____________ Work Phone:____________

Date of Birth:__________ SSN (last 4):________ Employer:____________________

Insurance Information (please fill out COMPLETELY or provide copy of insurance cards):

Primary Insurance:____________________ ID#____________ Group # ________

Subscriber:______________________________ Relationship to patient:____________

Secondary Insurance:__________________ ID#____________ Group # ________

Subscriber:______________________________ Relationship to patient:____________

Workers Compensation / L&I Information (please fill out COMPLETELY):

Employer Name where injury occurred ____

Address:____
(Street) (City) (State) (Zip)

Work Phone #____________ Date of Injury:______________________________

Workers Comp Insurance Company: ____

Address:____
(Street) (City) (State) (Zip)

Phone #__________ Claim #:______________ Claim Adjuster: ______________

Motor Vehicle Accident / Third Party Liability / Lawsuit (please fill out COMPLETELY):

Insurance Company: ____

Address:____
(Street) (City) (State) (Zip)

Phone #____________ Date of Accident:__________________________________

Name of Policyholder:________________________ Claim #____________________

Name of Attorney:____________________________ Phone #____________________

Address:____
(Street) (City) (State) (Zip)

If other, address to send claim to:

____

PLEASE FILL OUT COMPLETELY
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I AUTHORIZE THE SURGERY CENTER OF SILVERDALE, LLC, TO USE OR DISCLOSE HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name: ____

Date of Birth: ____________________ Patient's SSN: ______________________

☐ **Only the person who escorts me to and from SCS for my surgery is authorized to receive any information about my services.**

☐ **In addition to my escort, the following person(s) or organization(s) are authorized to receive information:**

Specific description of the information that may be used or disclosed (including date(s)):

Specific description of how the information may be used:

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1) I have been provided with a copy of the SCS Notice of Privacy Practices.
2) I understand that my health information will be shared for the purposes of treatment, payment and health care operations as permitted by HIPAA federal health care privacy regulations.
3) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying the Surgery Center of Silverdale, LLC, in writing.
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

______________________________________ ________________

Patient's Signature or Patient's Representative Date

______________________________________ ________________________

Printed Name of Patient's Representative Relationship to Patient