



1398 N Wilmot Rd. Tucson, Arizona 85712
(520) 731-5500

To all Prospective Patients:

The purpose of this mailing is to provide you with certain disclosures required by recent legislation. All patients must be provided with the enclosed information both verbally and in writing prior to the date of any procedure at the Tucson Surgery Center.

Enclosed you will find:

- ❖ Patients Rights and Responsibilities
- ❖ The Surgery Center's Policy on Advance Directives
- ❖ Pre-Registration Facility Disclosure Form

We are also required to provide this information to you verbally. A recording has been established at the Surgery Center for this purpose. Please dial (520) 731-5500 and press the # key to access this recording. Please choose option 1 for English or option 2 for Spanish.

You may also visit our website www.tucsonsc.com for full disclosure, map and other information.

You will be asked to sign an acknowledgement that you have received this information both verbally and in writing when you check in and register at the center on the day of your procedure.

It is also important that we gather your health history prior to your surgery date. Our Preadmissions Surgery Specialist will contact you prior to your surgery day to obtain your health history and discuss your pre-operative instructions.

Thank you for your cooperation and understanding with the above requirements. We look forward to providing you with an outstanding experience on the day of your procedure.

❖ For our Spanish Speaking Patients

Si usted necesita un paquete en Español, por favor llame al numero 731-5522. Gracias.

TUCSON
Surgery Center

1398 N. Wilmot Road Tucson, AZ 85712
520-731-5500

**TUCSON SURGERY CENTER
PATIENT CONSENT TO RESUSCITATIVE MEASURES**

All patients have the right to participate in their own health care decisions and to make advance directives or to execute the powers of attorney that authorize others to make decisions on their behalf based on the patients expressed wishes when the patient is unable to make or communicate decisions on their own. This surgery center respects and upholds those rights.

However, unlike in an acute care hospital setting, the surgery center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. You will discuss the specifics of your procedure with your physician, who can answer your questions as to the risks associated and your expected recovery and care after your procedure.

Therefore, it is our policy, regardless of the contents of any health care advance directives or instructions from a health care surrogate or an attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdraw of treatment measures already begun, will be ordered in accordance with your wishes, advance directives, or health care power of attorney.

**YOUR AGREEMENT WITH THIS POLICY BY YOUR SIGNATURE BELOW DOES NOT
REVOKE OR INVALIDATE ANY CURRENT HEALTH CARE DIRECTIVE OR HEALTH CARE
POWER OF ATTORNEY.**

**IF YOU DO NOT AGREE TO THIS POLICY, WE ARE PLEASED TO ASSIST YOU TO
RESCHEDULE THE PROCEDURE.**

Please check the appropriate box (or boxes) in answer to these questions:

Have you executed an Advance Directive, living will, or health care power of attorney that authorizes someone to make health care decisions for you?

- Yes, I have an Advance Directive, living will, or health care power of attorney.**
- Copy provided OR copy on file has been reviewed and is correct.**
- No copy provided at this time.**

- No, I do not have an Advance Directive, living will, or power of attorney.**
- I would like to receive information on Advance Directives.**

Please visit the Arizona Attorney General's website @ www.azsos.gov/advdir for more information and forms regarding Advance Directives.

By signing this document, I acknowledge that I have received this information, both verbally and in writing, prior to the date of my procedure. I have read and understand its contents and agree to the policy described. Also, if I have indicated that I would like additional information, I acknowledge receipt of that information.

SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT _____

If consent to the procedure is provided by someone other than the patient, this form must be signed by the person providing consent or authorization.

Please sign and bring this form with you on day of surgery.

TUCSON SURGERY CENTER
MEDIDA DE CONSENTIMIENTO
DE RESUCITAR AL PACIENTE

ESTE DOCUMENTO NO REVOCARA SU DIRECTIVO MEDICO O SU PODER MEDICO LEGAL

Todos los pacientes tienen el derecho de participar en su decisión médica y hacer un directivo médico o ejecutar un poder médico legal que autorice a otra persona hacer decisiones en su lugar basado en lo expresado por el paciente cuando el sea incapaz de tomar una decisión médica. Este Centro quirúrgico respetará y sostendrá esos derechos.

Sin embargo, a diferencia de un ambiente de hospital, este Centro quirúrgico **NO** ejecutará estudios o cirugías de alto riesgo. La mayoría de los estudios o cirugías ejecutados en este lugar son considerados de riesgo mínimo. Por supuesto, no hay cirugías sin riesgo. Usted y su médico hablarán sobre los riesgos, procedimientos, cirugías, recuperación y cuidados antes y después de su operación.

Por lo tanto, debido que esta es nuestra póliza no importa el contenido de cual esquire directivo médico o poder médico legal, en caso de que ocurra un evento inesperado durante su tratamiento en este centro quirúrgico nosotros iniciaremos medidas para resucitar, estabilizar y transportar el paciente al hospital más cercano para mayor evaluación. Ya en el hospital se le aplicará o se le quitará el tratamiento que se le empezó en acuerdo con sus deseos de su directivo médico o poder médico legal. Su acuerdo con esta póliza por medio de su firma no revoca o invalida ningún directivo médico o poder médico legal.

Si usted no está de acuerdo con esta póliza nosotros con gusto le daremos una nueva cita para su procedimiento. Por favor de marcar la pregunta apropiada. Ha usted hecho un directivo médico, testamento, o poder médico legal que autorice a una persona que haga decisiones médicas en su lugar?

- Sí, yo tengo un directivo médico, testamento o poder médico legal.
 - Copia recibida o archivada es correcta.
 - No copia recibida.
- No, yo no tengo directivo médico, testamento o poder médico legal.
- Me gustaría recibir información acerca de directivo médico.

Si usted marco *SI* a la primera pregunta, por favor de proveernos con una copia de ese documento para que sea parte de su archivo médico.

Por favor de visitar la página de internet de Arizona Attorney General's a https://www.azsos.gov/adv_dir para obtener más información acerca de directivos médicos y sus derechos.

Al firmar este documento, yo reconozco que he recibido esta información verbal y escrita antes de la fecha de mi procedimiento y que he leído y entendido su contenido y estoy de acuerdo con el contenido de la póliza.

Si, yo he indicado que me gustaría más información, y reconozco que la he recibido.

Por: _____ Fecha: _____
Firma del paciente

Relación al paciente: _____

Si el consentimiento para el procedimiento es dado por otra persona aparte del paciente, esta forma tiene que ser firmada por la persona que da consentimiento o autorización.

Por favor firme y traiga este documento con usted el día de su cirugía.



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PRE-REGISTRATION FACILITY
DISCLOSURE FORM

**Information Regarding Our
Complaint/Grievance Process**

If you have any concerns or complaints about the care you receive at the Tucson Surgery Center, you may contact the Administrator Natalie Graham at (520) 731-5501. Complaints or grievances may be made in verbal or written form. We guarantee that there will be no retaliation should the patient and/or the patient's representatives choose to report a complaint or grievance.

The center will investigate all complaints or grievances and respond to the patient in writing within seven (7) days of receipt of the complaint or grievance. The correspondence shall include the name of the facility contact person, steps taken to investigate the complaint or grievance, the results of the grievance process and the date of completion.

The patient or the patient's representative may also contact the Division of Health Care Facilities and Services Program Manager Kathryn McCanna, at 150 N. 18th Ave. Suite 450, Phoenix, Az. 85007-3245 Ph. (602)364-3030, mccannk@azdhs.gov; or you may contact the Office of Ombudsman-Citizens Aide, 3737 N. 7th St., Suite 209, Phoenix, AZ 85014 (602) 277-7292.

Disclosure of Physician Ownership

It is required by the Centers for Medicare and Medicaid Services that we notify all patients some surgeons who use our facility have financial interest in this facility and that there are alternative facilities available to you. The physicians listed below have an ownership interest in Tucson Surgery Center.

Charles Atkinson, MD
Barbara J. Aung, DPM
James C. Balserak, MD
Timothy A. Beer, MD
Robert Berens, MD
Khushvant S. Bhola, MD
Thomas E. Butler Jr., MD
Steve Cohen, M.D.
Amram Dahukey, DPM
Kathleen M. Duerksen, MD
Gary I. Goldstein, MD
James R. Herde, MD
James Hess, DO
Matthew Holland, MD
Susan J. Kalota, MD
Charles L. Krone, MD
Michael A. Lavor, MD
Glenn Nelson, DPM
Michael R. Probstfeld, MD
Randall S. Prust, MD
Joylon D. Schilling, MD
Mark Senese, MD
David B. Siegel, MD
Joel Thompson, MD
Eric Whitacre, MD

We are also required to provide this information to you verbally. A recording has been established for this purpose. Please dial (520) 731-5500 and press the pound (#) key. Please press 1 for English. You may also visit our website at www.tucsonsc.com for full disclosure.

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FORMA DE PRE-REGISTRO

Información Con Respecto a Nuestro Proceso de Queja o Agravio.

Si usted tiene cualesquiera preocupación o queja sobre el cuidado que usted recibe en el Tucson Surgery Center, usted puede comunicarse con la administradora Natalie Graham al número (520) 731-5501. Las quejas o los agravios se pueden hacer en forma verbal o escrita. Garantizamos que no habrá venganza si el paciente y/o el representante del paciente elige divulgar una queja o un agravio. El centro investigará todas las quejas o agravios y responderá al paciente por escrito dentro de siete (7) días de recibo. La correspondencia incluirá el nombre de la persona de contacto del centro, los pasos tomados para investigar la queja o el agravio, los resultados del proceso del agravio y la fecha de la terminación. El paciente o el representante del paciente puede también comunicarse con la división de instalaciones de cuidado médico y con Kathryn McCanna, 150 N. 18th Ave., Suite 450, Phoenix, AZ. 85007-3245, (602)364-3030, mccannk@azdhs.gov; o la Oficina del Ombudsman-Citizens Aide, 3737 N. 7th St., Suite 209, Phoenix, AZ 85014 (602) 277-7292.

Información Sobre El Interés Financiero del Medico en esta Facilidad

Es requerido por los Centros de Medicare y Medicaid que le notifiquemos a todos nuestros pacientes de ciertos doctores que tienen intereses financieros en esta facilidad y facilidades alternativas disponibles para usted si usted elige utilizarlas.

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Joel Thompson, MD
Eric Whitacre, MD

También nos requieren proporcionarle esta información verbalmente. Una grabación se ha establecido con este fin. Por favor marque el número (520) 731-5500 y oprima el signo del numero (#). Después oprima el número 2 para Español. Para mas información visite nuestra website a www.tucsonsc.com.



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TUCSON SURGERY CENTER

Patient Rights

YOU HAVE THE RIGHT TO:

- *Become informed of your rights as a patient both verbally and in writing prior to the date of your procedure in a language and manner that you understand. You may appoint a representative to receive this information for you.*
- *Exercise these rights without regard to sex, cultural, economic, educational or religious background or the source of payment for care; without being subjected to discrimination or reprisal and voice grievances regarding treatment of care that is (or fails to be) furnished.*
- *Dignified, considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect harassment and/or exploitation.*
- *Access protective and advocacy services or have these services accessed on the patient's behalf.*
- *Appropriate assessment and management of pain.*
- *Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.*
- *Knowledge of the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and healthcare providers who will see you. Change your provider, if other qualified providers are available.*
- *Knowledge of physician financial interests or ownership in the Surgery Center in writing in advance of the date of the procedure.*
- *Receive information from his/her physician about his/her illness, course of treatment, outcomes of care (including unanticipated outcomes), and your prospects for recovery in terms that you can understand. When medically inadvisable to give such information, the information will be provided to a person designated by you or a legally authorized person.*
- *Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.*
- *Receive information concerning the Surgery Center's policies on Advanced Directives, including a description of applicable state health and safety laws and, if requested official state Advance Directive forms in advance of the date of the procedure.*
- *Participate in the development and implementation of your plan of care and actively participate in decisions regarding your medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment, except when such participation is contra indicated for medical reasons.*
- *Have a family member or representative of your choice, or your personal physician, notified promptly of your admission to the facility.*

- *Full consideration of privacy concerning your medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be advised as to the reason for the presence of any individual involved in your healthcare.*
- *Confidential treatment of all communications and records pertaining to your care and your stay at the facility. Your written permission will be obtained before your medical records can be made available to anyone not directly concerned with your care.*
- *Receive information in a manner that you understand. Communications with you will be effective and provided in a manner that facilitates understanding. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.*
- *Access information contained in your medical record within a reasonable time frame.*
- *Reasonable continuity of care. Reasonable responses to any reasonable request you may make for service.*
- *Leave the facility even against the advice of your physician.*
- *Be advised of the facility's Grievance process should you wish to communicate a concern regarding the quality of the care you receive. Notification of the grievance process shall be given prior to the date of the procedure and includes: whom to contact to file a Grievance, and that you will be provided with a written notice of the Grievance determination that contains the name of the facility's contact person, the steps taken on your behalf to investigate the Grievance, the results of the process, and the completion date. You may also report complaints to the state agency as well as the office of the Medicare Beneficiary Ombudsman*
- *Resources:*
 - Division of Health Care Facilities and Services Kathryn McCanna, at (602) 364-3030 mccannk@azdhs.gov*
 - Or the Office of Ombudsman-Citizens Aide, 3737 N. 7th St. Suite 209, Phoenix, AZ 85014 (602) 277-7292.*
 - [Http://www.medicare.gov/ombudsman/resources.asp-Medicare](http://www.medicare.gov/ombudsman/resources.asp-Medicare) Ombudsman*
 - *www.cdc.gov/mmwr/about.html- Click on State Health Departments on lower left. See Map, choose state from Drop-Down Menu and search site for address and phone number of regulatory office*
 - *Attn: Administrative Director Tucson Surgery Center/Center for Pain Management. 1398 N. Wilmot Rd. Tucson, Arizona 85712 or (520)731-5501*
 - *www.medicare.gov or call 1-800-Medicare (1-800-633-4227)*
 - *<http://oig.hhs.gov-Office> of the Inspector General*
- *Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise your right to access care, treatment or services.*
- *Full support and respect of all patient rights should you choose to participate in research, investigation and/or clinical trials. This includes your right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).*
- *Be informed by your physician or a delegate of your physician of the continuing healthcare requirements following your discharge from the facility.*
- *Examine and receive an explanation of your bill regardless of source of payment.*
- *Know which facility rules and policies apply to your conduct while a patient.*
- *Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on your behalf.*
- *Be informed with appropriate information about the absence of malpractice insurance coverage.*

YOUR RESPONSIBILITIES AS A PATIENT:

- * To read and understand all permits and/or consents you sign. If you do not understand, it is your responsibility to ask the nurse or physician for clarification.
- * To read and reach your own decisions regarding Advance Directives and inform your provider about Living Will, medical Power of Attorney or other directive that could affect your care.
- * To provide, to the best of your knowledge, accurate and complete information regarding your health, past treatments, medications, including over the counter products and dietary supplements and any allergies or sensitivities.
- * To be involved and participate in all treatment plans as advised, as well as cooperate in informative decisions as deemed necessary.
- * To be respectful of all healthcare providers and staff, as well as other patients.
- * To follow any pre-operative written or oral instructions from the physician or surgical center.
- * To notify the physician or surgical center if these instructions have not been followed.
- * To provide an adult to transport you home after surgery if you have received medications and/or anesthesia.
- * To provide for someone to be responsible for your care for the first 24 hours after your procedure.
- * To follow carefully any written or verbal post-op instructions from your physician(s) or nurse.
- * To contact your physician regarding any post-operative question or problem
- * To assure all financial obligations for services are fulfilled as promptly as possible and to assume ultimate responsibility for payment regardless of insurance coverage.
- * To notify the surgical center if you feel any rights have been violated, or if you have a complaint or a suggestion for improvement, by returning your patient survey form.



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Acknowledgement of Required Disclosures

I acknowledge that I have received the following information both verbally and in writing prior to the date of my procedure:

- Patient Rights and Responsibilities
- The Surgery Center's Policy on Advanced Directives
- Advance Directive Forms if Requested
- Pre-Registration Facility Disclosure Form Containing the following:
 - Information Regarding the Complaint/Grievance process at the Tucson Surgery Center with Contact Information
 - Disclosure of Physician Ownership

Signature

Date

Please sign and bring this form
with you on day of surgery.

Patient Sticker