INNOVATIVE
SURGERY CENTER

Patient Handbook

- **What to bring to your appointment**
- **Pre Procedure Instructions**
- **HIPAA/Privacy Act Statement**
- **Patient Bill of Rights**
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Welcome to Innovative Surgery Center

Welcome and thank you for choosing Innovative Surgery Center. Our mission is to provide outstanding and compassionate non-operative and operative care using the least invasive yet most effective treatment available to restore your active lifestyle.

This patient handbook is designed to provide you with information about our practice as well as provide us with information to best care for you. Please take a few minutes to read the handbook, complete the forms in their entirety and bring the handbook with you on the day of your appointment.

We encourage you to ask any questions or share any concerns you might have during your first visit. We look forward to meeting you and providing you with excellent care. Please do not hesitate to call our office if you have any questions or visit our website at www.innovativesurgerycenter.com.

Sincerely,

The Physicians and Staff at Innovative Surgery Center

Please bring the following to your appointment:

- Your entire completed Patient Registration packet
- This Patient Handbook with the last page completed
- Insurance Card: For insurance questions please call 623-535-9777.
- Any copay and/or deductible payment
- Photo identification
- Any MRIs, X-rays, CT scans and/or EMGs and the written report (must be less than 1 year old). If you are following up from an emergency room visit, obtain your films and hand carry them or request delivery of your films and imaging report to our office.
- Current medication list and past medication (nonsteroidal and steroidal) that you have tried for pain.
- Conservative treatment records including: pain management, chiropractic treatment, activity modification, exercise programs and physical therapy. Bring documentation and/or name and phone number of conservative treatment office, type of treatment, and length of treatment.
- Outside Medical Records—please contact your physician's office and request to pick up your medical re- cords in person or have them fax your medical records, including imaging reports and any and all conservative treatment and past medications that have tried for pain, to our office at 623-236-3179 or mail to 15547 N. Reems Road, Ste A, Surprise, AZ 85374. If you need our office to facilitate your record's request, please complete the Record Release form in this packet and include your outside physician names, phone and fax numbers.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Innovative Surgery Center is committed to protecting your medical information. Further, we are required by law to maintain the privacy of your protected health information (PHI) and to give you this notice, explaining our legal duties and privacy practices with regards to your protected health information. We are required to must abide by the terms set forth in this notice. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. Any revisions will be posted in a prominent location in our office and, upon request, a copy will be provided to you of the revised notice. .

Uses and Disclosures of Your Protected Health Information:

1) **Treatment:** Your PHI may be used provide, coordinate, or manage your health care and any related services. We may also disclose your PHI to other health care providers who may be treating you or involved in your health care to ensure they have the necessary information to diagnose, treat or provide a service.
2) **Payment:** Your PHI may be used and disclosed to obtain payment for health care services provided by us or to determine whether we may obtain payment for services recommended for you. Your PHI may be disclosed to obtain payment or for payment activities from you, a health plan, healthcare clearinghouse, or a third party). As an example, we may need to include information that identifies you, your diagnosis, procedures performed, with a bill to a third-party payer or your health plan to agree to payment for that treatment.
3) **Health Care Operations:** We may use and disclose your PHI to support the business activities of our office. The activities include, but are not limited to, the evaluation of our team members in caring for you, quality assessment, the disclosure of information to physicians, nurses, medical technicians, medical students and other authorized personnel for education and learning purposes. As an example, we may use your protected health information to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. We may also disclose your protected health information to third party business associates who perform certain activities for us (e.g., billing and transcription services). Finally, we may disclose to certain third parties a limited data set containing your protected health information for certain business activities.
4) **Appointment Reminders/Treatment Alternatives/ Health-Related Services:** We may use and disclose your PHI to contact you to remind you that you have a scheduled medical appointment or to advise you of treatment options or alternatives or health related benefits and services which may be of interest to you.
5) **Facility Directory:** Unless you object, we may use and disclose in our facility directory your name, location in the facility, general condition and religious affiliation. All of this information, except for your religious affiliation, will be disclosed to persons who ask for you by name. Information in the facility directory may be shared with clergy.
6) **Persons Involved in Your Care:** We may use and disclose to a family member, a relative, a close friend, or any other person you identify, your protected health information that is directly relevant to the person's involvement in your care or payment related to your care, unless you object to such disclosure. If you are unable to agree or object to a disclosure, we may disclose the information as necessary if we determine that it is in your best interest based on our professional judgment.
7) **Notification:** We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or other person responsible for your care, of your location, general condition or death.
8) **As required by Law:** We will disclose your PHI when required to do so by international, federal, state or local law. Examples include:
    - Public health activities including reporting of certain communicable diseases,
    - Workers' compensation or similar programs as required by law,
    - Authorities when we suspect abuse, neglect, or domestic violence,
    - Health oversight agencies, including the Food and Drug Administration and Department of Health and Human Services
    - For certain judicial and administrative proceedings pursuant to an administrative order,
    - Law enforcement purposes, legal proceedings
    - Medical examiner, coroner, or funeral director,
    - The facilitation of organ, eye, or tissue donation if you are an organ donor,
    - To avert a serious threat to your health and safety or that of others,
    - For governmental purposes such as military service or for national security; and
    - In the event of an emergency or for disaster relief
    - Inmates, during the course of providing care
9) **Business Associates:** We may share your PHI with other individuals or companies that perform various activities on behalf of, our office such as after-hours telephone answering, quality assurance, or clinic research. Our Business Associates agree to protect the privacy of your information.
10) **Marketing & any purposes which require the sale of your information**: These disclosures require your written authorization.
11) **Any other uses and Disclosures not recorded in this Notice** will be made only with your written authorization. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your PHI, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Notice of Privacy Practices

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF INNOVATIVE SURGERY CENTER. THE INFORMATION CONTAINED IN IT BELONGS TO YOU.

BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1) **Copy of this notice:** You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.
2) **Inspect and Copy:** You have the right to inspect and copy your PHI that we maintain about you for as long as we maintain that information. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or PHI that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to review our denial. If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our Privacy Officer at the address listed below. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. Innovative Surgery Center has up to 30 days to make your PHI available to you (fee may apply), or 60 days if stored off-site, but must inform you of this delay.
3) **Request an Electronic Copy:** You have the right to request that an electronic copy of your PHI be given to you or transmitted to your designated officer. We will make every effort to provide the electronic copy in the format you request however if it is not readily producible by us we will provide it in either our standard format or in hard copy form (fee may apply).
4) **Request Restrictions:** You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment or health care operations. You may ask us not to use or disclose any part of your PHI and by laws we must comply when the PHI pertains solely to health care items or services for which the health care provider involved has been paid out of pocket in full. Request must be made in writing to our Privacy Officer with instructions. If we agree to the restriction, we may only be in violation of the restriction for emergency treatment purposes. By law, you may not request we restrict the disclosure of your PHI for treatment purposes.
5) **Right to receive Notice of a Breach:** You have the right to be notified upon a breach of any of your unsecured PHI.
6) **Request Amendments:** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. A request and the reason for the requested amendment must be in writing to the Privacy Officer as listed below. In certain cases we may deny your request. If we deny your request 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 a copy.
7) **Request Accounting of Disclosures**: You have the right to request a list of our disclosures of your protected health information, except for disclosures for treatment, payment, or health care operations; to you; incident to a use or disclosure set forth in this notice; to persons involved in your care; for notification purposes; for national security or intelligence purposes; to law enforcement officials; as part of a limited data set; that occurred before April 14, 2003 or six years from the date of the request. Your request must be in writing and must state the time period for the requested information. Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12- months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.
8) **Request Restrictions:** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.
9) **Request a Copy of Notice:** You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.
10) **File a Complaint**. You have the right to file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services if you believe we have violated your privacy rights. Complaints to our Privacy Officer must be in writing. We will not retaliate against you for filing a complaint.
11) If you have questions about this notice or would like additional information, please contact our Privacy Officer at:

Innovative Surgery Center, PH 623.535.9777 Fax 623.236.3179

By signing below, I acknowledge that I have received the Notice of Privacy Practices of this office, which outlines how patient confidential information will be used, disclosed, and protected. I understand that I may refuse to sign this Acknowledgement.

Patient Printed Name or Legal Representative: _____ Date of Birth: _____

Patient or Legal Representative Signature: _____ Date: _____

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

_____ Individual Refused to Sign _____ Communication Barrier _____ Care Provided Was Emergent

_____ Other: _____ Employee Initials: _____ Date: _____

Patient Bill of Rights & Responsibilities

Each patient has the right:

- To considerate and respectful care.
- To obtain from his/her physician complete current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.
- To participate in decisions involved in his/her care and to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment.
- To know the name of the person responsible for the procedure and/or treatment.
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action.
- To every consideration of his/her privacy concerning his/her medical care.
- To expect that all communications and records pertaining to his/her care, including financial records, should be treated as confidential and not released without written authorization by the patient.
- To obtain information as to any relationship of this facility to other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by names, which are treating him/her.
- To know if research will be done and the right to refuse to participate in such research projects.
- To expect reasonable continuity of care. The patient has the right to expect that this facility will provide a mechanism whereby he/she is informed by his/her physician of the patient's continuing health care requirements following discharge.
- To examine and receive an explanation of his/her bill regardless of the source of payment and to be informed regarding the fees for procedures performed in the center. The patient has a right to be informed of third party coverage including Medicare and Arizona Health Care Cost Containment System.
- To know what facility rules and regulations apply to his/her conduct as a patient.
- To request information about the grievance process at the facility. If a patient has grievance with the facility, he/she has the right to speak immediately with the Director of Nursing or the substitute person assigned to answer the grievances. A formal written grievance may be completed for further review of the grievance. All complaints will be reviewed within 60 days.
- To be free from chemical, physical, psychological abuse or neglect.
- To timely and appropriate pain management.
- To choose where to receive services, including a facility where his/her physician does or does not have an ownership interest.

Each patient has the responsibility:

- To read and understand all documents, consents and authorizations. If you do not understand, it is your responsibility to ask the nurse or physician for clarification.
- To fully participate in decisions involving his/her own health care and to accept the consequences of these decisions if complications occur.
- To provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over- the-counter products and dietary supplements and allergies and sensitivities.
- To provide a responsible adult to transport him/her home from the facility.
- To inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
- 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 be respectful of all health care providers and staff, as well as other patients.
- To follow his/her doctor's instructions, take medication when prescribed, and ask questions concerning his/her own health care that he/she feels are necessary.
- To contact the physician or nurse regarding any post-operative questions or problems.

FINANCIAL POLICY

Thank you for choosing Innovative Surgery Center as your pain management specialist. Please review and sign the following financial policy to indicate your agreement to these terms. Our financial policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients.

APPOINTMENTS

1) **No insurance card, referral, co-payment or outstanding balance.** Copayments and/or outstanding balances are due at the time of service. In addition, we may not be authorized to see you until referral authorization and insurance benefits have been obtained and/or verified. Your appointment may be rescheduled until such time that these document and/or payments are provided.
2) **Procedure Prepayment.** Innovative Surgery Center collects your payment for a procedure at the time when the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment, you may request a refund according to our refund policy (see below). We reserve the right to reschedule your procedure until prepayment has been made.
3) **Missed Appointments and Late Arrivals.** If you are more than 15 minutes late, we reserve the right to reschedule your appointment. If you are more than 60 minutes late, no show for an appoint, or do not give cancellation notice at least 24 hours in advance, you will be responsible for a missed appointment fee. The first 'missed appointment' occurrence will not be charged a fee. Any additional missed appointments will result in a missed appointment fee as follows:
    - Missed office visit appointments are subject to a $100 charge.
    - Missed procedure or appointments are subject to a $150 charge.
    - Missed massage appointments are subject to a $60 charge.

    These charges are your responsibility and will not be billed to any insurance carrier. It is at the provider's discretion to determine whether or not you will be dismissed from the practice due to missed appointments.

INSURANCE PAYMENTS

4) **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.
5) **Coverage Changes and Timely Submissio**n. It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Innovative Surgery Center must submit a claim on your behalf to your insurer. If Innovative Surgery Center is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.
6) **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by Innovative Surgery Center, then you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from our front desks). Self-pay patients are expected to make payment in full at the time of service, $250 consultation and $500 retainer fee.

BENEFITS AND AUTHORIZATION

7) **Insurance Plan Participation.** We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.
8) **Prior Authorization and Non-Covered Services.** Innovative Surgery Center may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. As a courtesy to our patients, Innovative Surgery Center makes a good faith effort to determine if services are covered by your insurance plan, and, if so, whether or not prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf.
9) **Out of Network Payments.** If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Innovative Surgery Center, immediately.

ACCOUNT BALANCES AND PAYMENTS

10) **Reassignment of Balances.** If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

11) **Collection of Unpaid Accounts.** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Innovative Surgery Center reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Innovative Surgery Center for any expenses incurred to collect your account, including reasonable attorneys' fees and collection costs of 25%.

12) **Returned Checks.** Returned checks will be subject to a $38 returned check fee.

13) **Refunds.** Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed.
Requests may be sent to: Innovative Surgery Center

14) **Forms and Records Requests.** I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.

15) **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

I have read and understand the financial policy of Innovative Surgery Center, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Innovative Surgery Center. I understand that I am financially responsible for all services I receive from Innovative Surgery Center. I understand that this financial policy is binding upon me, my estate, executors and/or administrators, if applicable.

Patient Printed Name or Legal Representative:_____ Date of Birth: _____

Patient or Legal Representative Signature:_____ Date: _____

INNOVATIVE
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PRE-PROCEDURE INSTRUCTIONS

1. Please take all regular scheduled medications before your scheduled appointment and eat **if you are not receiving sedation.**

2. **If you are receiving sedation** do not eat anything after midnight before your scheduled procedure.

3. If you are receiving sedation you will need a driver to and from the office. DRIVER MUST STAY AT THE OFFICE

4. All patients will need to be discharged to an adult. We cannot start the procedure until we see this person in the office.

5, All patients need medical clearance to stop blood thinners. **PLEASE LET THE STAFF KNOW IF YOU ARE ON BLOOD THINNERS** (Coumadin, warfarin, aspirin, xeralto etc.)

6. You can take pain medication such as over the counter Tylenol or other medication prescribed by your physician before leaving home.

7. Always shower or bathe prior to scheduled procedure especially the general areas of the body where you will be receiving your procedure. Wear loose comfortable clothes for scheduled procedure.

8. If you are taking **ANTIBIOTICS OR HAVE ANY ACTIVE INFECTIONS** please notify our office.

9. If needed **please** contact our office to cancel or reschedule your procedure 48 hours In advance. This will allow the opportunity for other patients to schedule a procedure as well.

10. Please contact our office to cancel your procedure and reschedule if you are ill or are recovering from any illness.

11. After your procedure you must wait a minimum of 20 minutes in the recovery room; make your next appointment as you leave.

12. Sometimes you may feel dizzy after the procedure, please ride home with car seat in reclined position, this will help minimize dizziness.

13. Rest or do light duties for the rest of the day if possible, then you may resume regular activities the next day. If you have sedation, please be aware that you **CANNOT** drive for the rest of the day.

14. After your procedure you may be sore when the numbing wears off. Apply ice every two hours for 10 minutes for the next 24 hours. On the second day you can use heat. You can take Tylenol or your regular pain medications.

Pain Medications and Driving

I consent to the treatment prescribed by my providers at Innovative, and I understand in the course of my treatment I may be prescribed medication(s) including narcotic pain medication(s).

- Patients on narcotic therapy choosing to drive may be charged for driving under theinfluence of drugs.
- Innovative Surgery Center is not responsible if a patient chooses to drive while taking prescribed medications which may cause drowsiness or decrease reaction time.
- If the manufacturer of a medication advises that a patient not drive while taking said medications, then it is the policy of Innovative Surgery Center to follow the recommendations of the manufacturer and instruct the patient not to drive while taking such medication(s).
- Patients assume the inherent risk of operating a vehicle while taking the medication(s).

Name of Patient/Legal Representative	Signature	Date

Acceptance of Innovative Policies & Procedures

Patients, please read the following and sign below.

- My signature indicates that I have received and read the Innovative Patient Handbook containing the HIPAA Privacy Act Statement, Patient Bill of Rights, Innovative Financial Policy and Consent to Treatment and Release of Liability, etc.
- I have had the opportunity to ask questions regarding the information in this handbook prior to signing this agreement.
- I understand and agree to abide by any and all of the rules and regulations contained in this Patient Handbook.

Name of Patient/Legal Representative **Signature** **Date**

Authorization to Pay

I request payment of authorized Medicare and/or insurance benefits to be made on my behalf to Innovative Surgery Center for any services provided for my care by their physicians/providers.

I authorize any holder of my medical information to release all information necessary to the Health Care Financing Administration/Center for Medicare/Medicaid Services, and other Insurance Companies I have listed, and its agents to determine benefits payable for medical treatment received at Innovative.

I authorize any holder of my medical information including Government, Medicare/Medicaid, Primary Care Physician, and Insurance companies to release all information necessary to determine benefits payable for medical treatment received at Innovative.

Name of Patient/Legal Representative **Signature** **Date**

Authorization to Use and Disclose Protected Health Information

I hereby permit Innovative Surgery Center to use and disclose my Protected Health Information (PHI) to any third party **payor**, or to any party involved in my health care. By signing this Authorization, I understand the following (1) I have the right to revoke this Authorization, by sending **written** notification to Innovative. Once Innovative receives the written revocation this Authorization will be revoked, except to the extent that Innovative has already taken action in reliance upon this Authorization; (2) Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal or State Law; (3) This Authorization shall be enforced as long as I am a patient of this practice. **Unless**, I give written notice to revoke my Authorization; and (4) I have a right to refuse to sign or revoke this Authorization as Innovative may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization.

Name of Patient/Legal Representative **Signature** **Date**

Consent for Release of Medical Information

I hereby authorize Innovative Surgery Center to convey to any physician and/or any medical facility directly involved with my care, my medical history, laboratory reports, x-rays, and any other material services, consultations, and treatments which I received while under his/her care.

Name of Patient/Legal Representative **Signature** **Date**