PATIENT: _____

DATE OF SERVICE: _____

Dear Patient,

Thank you for scheduling your procedure at Greenway Surgery Center. Your physician designed this facility with you in mind, and recommends treatment here to provide you with the highest level of patient care. We are proud to serve you and are committed to meeting your healthcare needs in a state of the art environment, with a first rate staff and excellence in patient satisfaction.

Although Greenway Surgery Center is not currently a participating provider with your Insurance Plan, we strive to give our patients the best possible value for their health care dollar, and we want to make it as simple as possible for you to manage the costs of services. While we cannot waive the patient responsibility required by your health plan, we are able to discount the cost of care. Our discount program allows us to provide access to superior quality to all patients in the community, regardless of insurance type, at a cost-effective rate for you, your family and your health plan.

A member of our staff will call you prior to surgery to discuss pre-operative orders and your insurance coverage. Since we are unable to determine the exact amount your insurance will cover prior to your procedure, we request a deposit on your date of service, which will be applied to your total financial responsibility. Actual cost of care varies because the services we provide are individualized to best meet your needs. We will submit a claim to your insurance company on your behalf, and once the claim has been processed by your insurance carrier, we will send you a bill for any remaining balance, based on the amount allowed by your insurance company and you're in-network benefits. Our pricing is competitive, and the total out of pocket expenses will be approximately the same, or less than what you would pay at another facility. Payment plans are available to assist in managing your health care expenses, and we encourage you to share your questions with our staff prior to your procedure so we can make your visit relaxed and hassle-free.

It is possible that the insurance payment for your visit will be sent directly to you. We ask that you please endorse the check over to the facility, and mail it, along with your Explanation of Benefits. Compliance with this request will allow us to process the payment to your account quickly and efficiently, and make any necessary adjustments.

If you have any questions or concerns, please do not hesitate to call our billing office at 612-728-2668 between the hours of 9:00 – 5:00 Mon-Fri.

We look forward to serving you, and appreciate being your preferred choice for surgical care.

Patient Signature	Date	Witness Signature	Date

AUTHORIZATIONS & DISCLOSURES

These AUTHORIZATIONS & DISCLOSURES MUST BE SIGNED BY THE PATIENT, or by the party legally and financially responsible for a minor or physically or mentally incapacitated patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

AUTHORIZATION FOR MEDICAL TREATMENT: I, the undersigned (also referred to herein as the "patient") hereby authorize any anesthesia, medical, or surgical treatment, including services rendered or provided under the general and special instructions of my attending physician, his/her assistants, and other practitioners associated, as may, in their professional judgment be deemed necessary or beneficial for the purposes of diagnosis, treatment, and medical care at Greenway Surgery Center. NO PROMISE, GUARANTEE OR WARRANTY HAS BEEN MADE REGARDING THE RESULTS OF ANY MEDICAL TREATMENT OR SURGICAL PROCEDURE. Any and all removed organs or parts may be disposed of in accordance with accepted medical practices.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I, the undersigned, hereby authorize the release of my health records, including, but not limited to, laboratory reports, x-rays, prescriptions, and other technical information used to assess my condition before, during, and after my admission and treatment at [SURGERY CENTER] to SURGERY CENTER. This includes the pertinent portion of my health record relating to a specific condition, or a summary of my health record. This consent satisfies the requirements for the release of records under Minnesota law. For purposes of reimbursement, Greenway Surgery Center and each attending or treating practitioner, including, but not limited to, pathology, anesthesia, radiology, and laboratory providers, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my employer, insurance companies, other organizations, third party payors, or agencies as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement. I understand that such disclosures may contain information which could result in limitation or denial of insurance benefits or third party reimbursement or which could otherwise be harmful or prejudicial to my interests. Unless specifically instructed otherwise, Greenway Surgery Center and each attending or treating practitioner are hereby authorized and directed, during the period of this admission, to disclose information to the patient's spouse, children, parents, and any other person authorized to consent to treatment pursuant to Minnesota law, as amended, concerning the patient's health status, diagnosis, prognosis, and progress.

Each of the undersigned do hereby release and hold Greenway Surgery Center, its officers, directors, agents, employees, and all examining and treating practitioners harmless of and from any and all costs, loss damage, or liability resulting from or arising out of such disclosures.

RELEASE OF RESPONSIBILITY FOR VALUABLES: Greenway Surgery Center is hereby fully released of and from any and all responsibility for loss or damage to the personal property, money, or valuables of the undersigned patient.

NOTICE OF PRIVACY PRACTICES: I am aware of my rights to privacy of personal health information, under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and am aware that a copy of these rights are available to me upon request.

RIGHTS AND RESPONSIBILITIES: I acknowledge that I have received, prior to my procedure, a copy of the Patient Rights and Responsibilities, which includes information regarding where and how I can file a grievance or complaint.

PHYSICIAN OWNERSHIP DISCLOSURE: Greenway Surgery Center provides services only to patients admitted by private practitioners who are members of the Medical Staff, some of whom retain joint ownership of the surgery center. I understand I may choose another facility for the services I require, and have elected to receive care at Greenway Surgery Center .

TRANSPORTATION RELEASE: I understand that if the anesthetic/sedation to be administered to me may have effects that make it hazardous for me to drive a car or otherwise travel alone to my home following my procedure and discharge. I have arranged for transportation with a responsible adult to my home and will be under the supervision of a responsible adult for 24 hours following my procedure. I understand that Greenway Surgery Center will not perform my schedule procedure unless these arrangements are met, and have provided Greenway Surgery Center with my designated responsible party's name and phone number. <u>The responsible party agrees to assume responsibility for accompanying and transporting the named patient to his/her home.</u>

Name of Responsible Party | Signature of Responsible Party | Phone Number

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I have received information about the Advanced Directives Policy at Greenway Surgery Center and I understand that the center policy (regardless of the contents of any advance directive or instructions from a health care surrogate attorney in fact) is to initiate resuscitative measures, should an adverse event occur during my procedure. I would be transferred to the closest acute care facility for further evaluation, where further treatment or withdrawal of treatment measures already begun will be ordered in accordance with my wishes, advance directive or health care power of attorney. My agreement with this policy does not revoke or invalidate any current health care directive or health care power of attorney.

Please check one of the following:

- ○ YES, I brought my Advanced Directive/Living Will/Health Care Proxy with me to place a copy in my chart as part of my medical record
- ○ YES, I have an Advanced Directive/Living Will/Health Care Proxy, but did not bring it with me
- ○ NO, I do not have an Advanced Directive/Living Will/Health Care Proxy
- ○ I wish to have information on how I can obtain an Advanced Directive/Living Will/Health Care Proxy

NOTICE OF FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to Greenway Surgery Center for any and all charges associated with the services rendered by [Surgery Center], whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. Greenway Surgery Center verifies insurance benefits, however exact coverage and benefits cannot be determined until the claim is received and reviewed by my insurance carrier. I understand this is not a guarantee of payment from an insurance carrier, and all benefits are subject to the conditions and limitations of the plan and are subject to change. I understand that I am financially responsible for charges not covered by an assignment of benefits, or for charges which the insurance carrier declines to pay. When a health plan denies some or all of the charges, Greenway Surgery Center will pursue the internal appeals provided by the health plan, and will bill the patient for any amounts which remain outstanding after the appeals are exhausted. I further acknowledge:

1. Greenway Surgery Center may be a non-participating provider with my insurance plan, the status of which I have been informed of, and I have chosen to obtain services at this facility.
2. Greenway Surgery Center bills both patients and health plans using the same fee schedule, and my financial obligation is based on my applicable benefit levels associated with services for which Greenway Surgery Center will bill my health plan pursuant to an assignment.
3. Where contractual rates do not apply, patients and health plans are offered discounts, in accordance with the Greenway Surgery Center Financial Policies, a copy of which is available to me upon request, and has also been made available to my health plan.
4. I am aware of my right to request a complete written estimate of the anticipated charges, and my associated financial responsibility. I understand that the fee quoted to me for the surgery facility is an ESTIMATE only, and it is possible that I will receive a bill for any balance which I remain financially obligated to pay.
5. Fees for anesthesia services, physician fees, pathology services, laboratory fees, durable medical equipment, and surgical assistants, or other services rendered which are not included in the facility global rate will be billed separately where applicable.
6. When a payment is received by the patient, directly from the health plan they have assigned to Greenway Surgery Center, patient must endorse and forward the payment and Explanation of Benefits to Greenway Surgery Center as soon as the payment is received to avoid additional financial liability.

MEDICARE CERTIFICATION AND AUTHORIZATION: Each of the undersigned certifies that the information given in applying for payment under Title XVII of the Social Security Act, if applicable, is correct. Any holder of medical or other information about the patient pertaining to this admission, is authorized by the Social Security Administration as applicable, or their intermediaries or carriers, any information needed for any Medicare claim and to request that payment of authorized benefits be made on the patient's behalf. The Medicare program is authorized to furnish medical or other information needed for any Medicare claim and to request that payment of authorized benefits be made under Title XVII as necessary to process any complimentary coverage claim.

THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.

PRINT NAME OF PATIENT/ REPRESENTATIVE & FINANCIALLY RESPONSIBLE PARTY	SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE & FINANCIALLY RESPONSIBLE PARTY	RELATIONSHIP	DATE

PRINT NAME	TITLE	WITNESS SIGNATURE	DATE

NOTICE OF PRIVACY PRACTICE as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Effective April 14, 2003

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.

Greenway Surgery Center (ASC) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about the privacy practices at ASC, please see the contact information at the end of this document.

I. HOW ASC MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

ASC collects and protects the privacy of your health information. The law permits ASC to use of disclose your health information for the following purposes:

1. **TREATMENT**: ASC may use your health information to provide you with medical treatment or services. For example, information obtained from you by a front office personnel or nurse is necessary to determine what treatment you should receive.
2. **PAYMENT:** ASC may use and disclose health information about you for payment for treatment and services you receive. For example, your health information may be sent to a third party payer such as an insurance company or health plan in order for ASC to receive payment for services rendered.
3. **HEALTHCARE OPERATIONS:** ASC may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and other to evaluate the performance of our staff, assess the quality of care and outcomes in your case and similar cases, and to determine how to continually improve the quality and effectiveness of the health care we provide.
4. **INFORMATION PROVIDED TO YOU AND ON YOUR AUTHORIZATION:** You may give ASC written authorization to use or disclose your health information.
5. **NOTIFICATION AND COMMUNICATION WITH FAMILY:** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. **REQUIRED BY LAW:** As required by law, ASC may use and disclose your health information. For example, ASC may disclose health information for the following reasons; judicial and administrative proceedings, to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes; to the Department of Health and Human Services to determine if we are in compliance with federal laws; or to appropriate persons in order to prevent or lessen a serious and imminent threat to the public or safety of a particular person or the general public.
7. **PUBLIC HEALTH:** As required by law, ASC may use and disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; to aid with disaster relief, and reporting disease or infection exposure.
8. **HEALTH OVERSIGHT ACTIVITIES:** ASC may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure, and other proceedings.
9. **DECEASED PERSON INFORMATION AND ORGAN DONATIONS:** ASC may disclose your health information to coroners, medical examiners, funeral directors, or to organizations involved in procuring, banking or transplanting organs and tissues.
10. **RESEARCH:** ASC may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.
11. **WORKER'S COMPENSATION:** ASC may disclose your health information as necessary to comply with worker's compensation laws.
12. **MARKETING:** ASC may contact you to give you information about treatments or health –related benefits and services that may be of interest to you.
13. **GOVERNMENT FUNCTIONS:** Specialized government functions such as protection of public officials or reporting to various branches of the armed services may require use or disclosure of your health information.
14. **APPOINTMENTS:** ASC may use your information to provide appointment reminders by telephone, email or postal service.
15. **BUSINESS ASSOCIATES:** We work with other businesses to help ASC operate successfully. We may disclose your health information to these business associates so that they can perform the tasks we hired them to do. Our business associates must guarantee us that they will respect the confidentially of your personal health information.

II. WHEN ASC MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in the Notice of Privacy Practices, ASC will not use or disclose your health information without your written authorization.

III. YOUR HEALTH INFORMATION

1. You have the right to request restrictions on certain uses and disclosures of your health information. ASC is not required to agree to the restrictions that you request.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location. Request must be made in writing detailing the alternative methods chosen and could be applicable to fees.
3. You have the right to inspect and/or obtain a copy of your health information for a reasonable fee.
4. You have the right to request that ASC amend your health information that is incorrect or incomplete. ASC is not required to change your health information and will provide you information about the denial process.
5. You have the right to receive and accounting or disclosure of your health information made by ASC except that ASC does not have to account for the disclosure described in treatment, payment, healthcare operation, and government functions of section I of this notice. The first accounting of disclosers within a twelve-month period is free. Any additional accountings in that time frame are subject to a fee.
6. You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
7. You have the right to obtain a paper copy of this Notice upon request.
8. You have the right to be notified in the event of a breach in ASC's patient information.
9. You have the right to request that your health plan not be informed of your treatment at ASC if you pay in full and your insurance company is not billed.

IV. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

ASC reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, ASC is required by law to comply with this notice. A paper copy of this notice is available if you request a copy.

V. COMPLAINTS

If you believe that your privacy rights have been violated or if you have complaints about this Notice of Privacy Practices, contact the ASC Administrator at:

Greenway Surgery Center
2020 East 28th St Suite 100
Minneapolis, MN55407
Phone: 612-728-7000 Fax: 612-728-2660

If you are not satisfied with the manner in which ASC handles a complaint, you may submit a formal written complaint to the Department of Health and Human Services, Office for Civil Rights. You will not be retaliated against for filing a complaint.

**To receive this notice of privacy practices in another language please use the reference links below.
http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html
Language Line – Pay as you go – 800-752-6096 www.languageline.com