

# PUGET SOUND

## SURGICAL CENTER



### PATIENT RECORD OF DISCLOSURES

**NAME:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_

**I wish to be contacted in the following manner (check all that apply):**

**Cellular Telephone Number** \_\_\_\_\_

- OK to leave message on machine/voicemail, with detailed information
- OK to leave message with detailed information, with (specify name) \_\_\_\_\_
- Leave message with call-back number only

**Home Telephone Number** \_\_\_\_\_

- OK to leave message on machine/voicemail, with detailed information
- OK to leave message with detailed information, with (specify name) \_\_\_\_\_
- Leave message with call-back number only

**Work Telephone Number** \_\_\_\_\_

- OK to leave message on machine/voicemail, with detailed information
- OK to leave message with detailed information, with (specify name) \_\_\_\_\_
- Leave message with call-back number only

#### Written Communication

- OK to mail to my home address
- OK to mail to my work/office address
- OK to email to: \_\_\_\_\_@\_\_\_\_\_.\_\_\_\_\_
- OK to fax to this number \_\_\_\_\_

**Other** \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# Puget Sound Surgical Center Financial Policy

**Welcome to our practice, please review and sign our financial policy.**

We require payment pre-authorization for services to be rendered. Please complete the attached form, which will be securely kept on file for your convenience.

Referrals: If your insurance requires a referral, please bring that with you on your first visit.

Insurance Plans: As a courtesy to our patients, we will file your claims for you to your insurance company. If for some reason your insurance company declines to pay for the services rendered, then you, the patient, are responsible for the entire bill. Any co-pays, co-insurance and deductibles will be collected at the time of service.

Surgical Procedures: If you are to have surgery, our office will contact your insurance company for benefits and pre-authorization. Prior to the procedure being completed, our office will contact you regarding your financial responsibility. Any amounts due to PSSC from patient for surgeries are to be paid 1 (one) week prior to the scheduled procedure. If for some reason payment is not collected and/or other arrangements have not been made, then the surgical procedure will be postponed.

Labor and Industries: Labor and Industries patients are welcome. Since we are not primary care providers, a referral is required from your primary care doctor upon your first visit.

Self-Pay Patients: Payments are due at the time services are rendered. We may be able to give you an estimate over the phone, but please remember it is only an estimate. Charges will be determined once the patient has actually seen the doctor.

Forms: It is inevitable that forms unrelated to the filing of medical insurance claims, such as return to work and disability applications, time loss reports, and Family Medical Leave Act (FMLA) be provided by us. We will provide, free of charge, the first FMLA/disability form that a patient requires for each episode of surgery. Additional forms will be completed at a rate of \$20 per form. The fee MUST be paid in full at the time the form is dropped off. Please allow 5 business days for completion of forms.

Delinquent Accounts: Any accounts 90 days or older will be forwarded to our collection agency. The patient will be responsible for any fees incurred by PSSC to collect this debt. Fees include, but are not limited to, collection fees, attorney's charges and/or court fees incurred by PSSC.

Return Check Policy: There is a \$25.00 service fee on each returned check. A NSF check must be redeemed with cash within 5 business days of bank notification.

Minor Patients: An adult or legal guardian must accompany all minors to each office visit. The adult or legal guardian accompanying the minor assumes all financial responsibility for the cost of the minor's visit.

Attorney Protections/Letters of Guarantee: PSSC does not accept letters of guarantee from attorney offices.

If you cannot make your scheduled appointment time, please contact our office 24 hours prior to your appointment. If you cannot keep your surgery date or time, we require at least a 72 hour notification.

I have read and understand the above financial policy and agree to abide by the terms of this policy. For your convenience, PSSC accepts the following forms of payment: Visa, MasterCard, cash, check, money orders and cashier's checks.

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**Patient Signature**

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**Date**

*revised 1/2010*



## **APPOINTMENT/SURGERY CANCELLATION POLICY**

Our goal is to provide quality medical care in a timely manner. In order to do so we have implemented an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

### **Cancellation/"No Show" of an Appointment**

In order to be respectful of the medical needs of our patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment we require that you provide 24 hours notice. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. Failure to provide 24 hours notice, or a "No Show" for an appointment will result in a **fee of \$50** to be billed to you for payment.

### **Cancellation/"No Show" for a surgery or procedure**

Please provide a minimum of 48 hours notice to cancel or reschedule your surgery or procedure. Failure to provide a minimum of 48 hours notice to cancel or reschedule your surgery, or a "No Show" for your surgery will result in a **fee of \$300** to be billed to your account. Failure to provide a minimum of 48 hours notice to cancel or reschedule your procedure or a "No Show" for your procedure will result in a **fee of \$125** to be billed to your account.

### **Cancellation/"No Show" for Cosmetic Surgeries**

Policy for Cosmetic Surgeries is as follows:

**10% of the total fee** if cancelled 4-8 days before surgery date

**25% of the total fee** if surgery is cancelled 3 days or less before the surgery date

Please call our office to cancel or reschedule your appointment at:

Edmonds location: 425.778.2220

Bellingham location: 360.676.1111

We understand that there may be unforeseen emergencies that may not allow for you to give the required notice, and exceptions to the policy may be made by management.

**I have read and acknowledge receipt of the cancellation/No show policy**

\_\_\_\_\_  
**Printed Patient Name**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

# HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

We understand that information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose your health information. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

## **We are required by law to:**

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the notice that is currently in effect.

## **How we may use and disclose health information about you:**

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by law
- To avert a serious threat to health and safety
- As required by the Military of Veterans and Worker Compensations
- Public Health Risks
- Health oversight activities
- Lawsuits and Disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Official for inmates

## **Your rights regarding health information about you:**

- Right to inspect and copy
- Right to amend
- Right to an accounting of disclosures
- Right to request a restriction
- Right to request confidential communication
- Right to a paper copy of this notice (full notice is available upon request).

## **Changes to this notice:**

We reserve the right to change this notice. We will post a copy of this current notice in our facility with the current effected date on this page.

## **Complaints**

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

## **Acknowledgement of receipt of this notice:**

We will request that you sign a separate form acknowledging that you have received a copy of this notice. This acknowledgement will become part of your records.

## **NOTICE OF PRIVACY PRACTICE-ACKNOWLEDGEMENT**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below I acknowledge receipt of the Notice of Privacy Practice.**

\_\_\_\_\_  
Patient signature or legal authorized individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship to patient

# **PATIENT RIGHTS AND RESPONSIBILITIES**

**This facility and medical staff have adopted the following list of patient rights and responsibilities. This list includes, but is not limited to:**

## **PATIENT RIGHTS**

- Impartial treatment without regard to race, color, sex, national origin, religion, handicap or disability.
- Considerate and respectful care at all times and under all circumstances.
- To receive care free from abuse.
- Knowledge of the name and professional status of those caring for you.
- To receive information from the surgeons about your diagnosis, treatment plan and prognosis to the best of the physicians' knowledge.
- To participate actively in decisions regarding your medical care. To the extent permitted by law, this includes the right to refuse treatment.
- Full consideration of privacy concerning your medical care program. Case discussion, examination and treatment are confidential and should be conducted discretely.
- To be informed that Advanced Directives cannot be honored at this facility and to be advised that should an unexpected life threatening event occur the patient will be transferred to a facility that will honor this directive.
- Confidential treatment of all communications and records pertaining to care. Written permission shall be obtained before medical records can be made available to anyone not directly concerned with your care.
- Responsible responses to any reasonable request for service.
- To leave the facility even against medical advice.
- To expect reasonable continuity of care.
- To be advised if the physician proposes to engage in or perform experimentation affecting your care or treatment and the right to refuse to participate in this activity.
- To be informed of the continuing health care requirements following discharge from the center.
- Examine and receive an explanation of a bill for service, regardless of source of payment.
- To report any comments concerning the quality of care provided to you and expect follow-up on your comments.

## **PATIENT RESPONSIBILITIES**

- To provide accurate and complete information concerning his/her present complaints, past medical history and other matters relating to their health.
- To notify us of the existence of an Advanced Directive (e.g. a living will) as those cannot be honored at this facility.
- To make it known whether he/she clearly comprehends the course of treatment and what is expected of him/her.
- For following the treatment plan established by the physician, including the instructions of nurses and other health care professional as they carry out the physicians' orders.
- For keeping his/her appointment and notifying the facility if unable to do so.
- To provide a responsible adult to drive them home and stay with them 24 hours after surgery.
- For assuring that the financial obligations of their care is fulfilled as promptly as possible.
- For being considerate of the rights of other patients and facility personnel.

## PATIENT RIGHTS AND RESPONSIBILITIES (cont.)

### FEEDBACK

Our goal is to provide the best surgical experience possible while in our Ambulatory Surgery Center. Patients, clients, families or visitors have the right to express complaints or concerns about any aspects of their care or experience with our ASC. Please be assured that expressing a complaint or concern will not compromise your care and will be addressed according to our policy. Concerns may be directed to any facility staff or the ASC Manager, or you may mail your comments to us.

If you feel it is necessary, complaints may also be shared with:

**MARY SELECKY, SECRETARY OF HEALTH  
WASHINGTON STATE DEPARTMENT OF HEALTH  
HEALTH SYSTEMS QUALITY ASSURANCE  
COMPLAINT INTAKE  
310 ISRAEL ROAD SE  
P.O. BOX 47857  
OLYMPIA, WA 98504-7857  
360-236-4700  
[HSQAComplaintIntake@doh.wa.gov](mailto:HSQAComplaintIntake@doh.wa.gov)**

**OFFICE OF THE MEDICARE BENEFICIARY OMBUDSMAN  
OFFICE OF THE REGIONAL ADMINISTRATOR  
DIVISION OF SURVEY AND CERTIFICATION OPERATIONS  
CHRIS MARTIN, BRANCH MANAGER  
2201 6TH AVENUE, SUITE 801  
SEATTLE, WA 98121, 206-615-2313  
1-800-MEDICARE (1-800-633-4227)  
1-877-486-2048 (TTY)  
[www.medicare.gov](http://www.medicare.gov)**

**STATEMENT OF PHYSICIAN FINANCIAL INTERESTS OR OWNERSHIP** Your physician has an ownership interest in Puget Sound Surgical Center which includes the surgery center at which you are having your procedure. As with all of your care, you may request to have your procedure performed at another facility where your surgeon has privileges to practice.

### ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

Our **Patient Rights and Responsibilities** statement describes in more detail your rights and responsibilities as a patient of Puget Sound Surgical Center.

**By my signature below I acknowledge receipt of the Patient Rights and Responsibilities statement.**

\_\_\_\_\_  
**Patient Signature or legally authorized individual**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name if signed on behalf of the patient**

\_\_\_\_\_  
**Relationship to patient**

# Puget Sound Surgical Center

PATIENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
 SOC. SEC. # \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_  MALE  FEMALE  
 Mailing Address \_\_\_\_\_ APT # \_\_\_\_\_  
 \_\_\_\_\_ - \_\_\_\_\_ Email Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ + 4 \_\_\_\_\_  
 HOME PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

**REFERRED BY** \_\_\_\_\_ **PRIMARY CARE DR** \_\_\_\_\_

MARITAL STATUS:  Single  Married  Widowed  Divorced  Separated  Other \_\_\_\_\_  
 RACE (optional):  Caucasian  African American  Hispanic  Pacific Islander  Asian  
 Asian American  American Indian  Other \_\_\_\_\_

RESPONSIBLE PARTY: (if other than patient) Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to patient \_\_\_\_\_

PATIENTS EMPLOYER _____	SPOUSES EMPLOYER _____
<input type="checkbox"/> Full-Time	<input type="checkbox"/> Full-Time
OCCUPATION _____ <input type="checkbox"/> Part-Time	OCCUPATION _____ <input type="checkbox"/> Part-Time
ADDRESS _____	ADDRESS _____
CITY, STATE, ZIP _____	CITY, STATE, ZIP _____

<b>IN CASE OF EMERGENCY NOTIFY:</b>	<b>OKAY TO DISCLOSE INFORMATION</b>
_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Name _____ Relationship _____ Phone number _____	
_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Name _____ Relationship _____ Phone number _____	

**PREFERRED PHARMACY:**

Pharmacy \_\_\_\_\_ Address \_\_\_\_\_  
 Phone \_\_\_\_\_ City, ST, Zip \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

# Puget Sound Surgical Center

**PRIMARY INSURANCE:** \_\_\_\_\_ PLAN COPAYS\$ \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
Street or PO Box City, State Zip+4

Insurance Company Phone Number: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Group ID #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to the Patient: \_\_\_\_\_

Male  Female Birth Date: \_\_\_\_\_ Soc. Sec.#: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ PLAN COPAYS\$ \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
Street or PO Box City, State Zip+4

Insurance Company Phone Number: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Group ID #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to the Patient: \_\_\_\_\_

Male  Female Birth Date: \_\_\_\_\_ Soc. Sec.#: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

## NOTES:

I hereby authorize my insurance benefits be paid directly to the physician. I also authorize the doctor or insurance company to release information required for this claim. I consent to the release of medical information from or to other doctors and healthcare institutions as is necessary to my care and treatment.

Payment: I am financially responsible for any balance due, I agree to make payment arrangements; pay \$5 per month on unpaid balances over 30 days and all the reasonable expenses such as attorney fees and court costs should account be referred for collections.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_