ORANGE CITY SURGERY CENTER

Patient's Rights and Responsibilities

I certify that I, a patient/responsible party or legal guardian at Orange City Surgery Center, have received a copy of the "Patient's Rights and Responsibilities" have read them and understand them completely, in their entirety.

Please circle: Yes No

Living Wills, Do Not Resuscitate Orders

I have a Living will: Please circle: Yes No

PLEASE NOTE: "LIVING WILLS" AND/OR "DO NOT RESUSCITATE" ORDERS ARE NOT HONORED AT THIS FACILITY. If an Emergency occurs and you need acute care, our policy is to transfer you to a facility that can provide such care at that time. Please elect with an X the appropriate response below:

☐ I understand this statement and agree to be transferred to an acute care facility if a life threatening event occurs; I agree to have all my medical records and belongings transferred with me.

☐ I understand this statement, yet do not wish to waive my right to execute my living will. I understand that this means I cannot have my procedure performed in this facility and will discuss this further with my Physician.

HIPAA (HEALTH INSURANCE AND PORTABILITY AND ACCOUNTABILITY ACT) I have read the copy of the HIPAA policy and I agree to the following things. Please circle Yes or No to the following questions:

OK to call my home Yes No

OK to leave a voice message on machine Yes No

OK to leave a voice message with Spouse/Significant Other Yes No

List Alternative Contacts: ______________________________

OK to discuss information regarding my procedure with (list): ____________________

We will be sharing Medical Information with the following-any objection should be in writing:

- Surgeon
- Insurance Company
- Anesthesia Providers, Laboratory Services, Radiology Services
- Federal, State and Local regulatory agencies
- Peer review, committees for Performance, Improvement of Orange City Surgery Center

We will make available to you the" Notice of Patient Information Privacy Practices" that provides a more complete description of health information uses and disclosures as required by the HIPAA standard. You have the following right:

The right to read the "Patient Health Information Privacy Practices" prior to signing your consent and the right to request a copy for your own personal use.

I fully understand and agree to this consent and acknowledge the above rights and disclosures.

If patient is a minor Parents must stay in the Surgery Center during the procedure.

Signature of Patient/Responsible Party:	Date:
DATE FORM RECEIVED BY PATIENT FROM DOCTORS OFFICE:	