# Highland Springs Surgical Center

Welcome to Highland Springs Surgical Center. Your physician has scheduled you for a surgery/procedure at our facility and there are a few forms that we would like you to fill out prior to your arrival. This will greatly expedite your registration process upon arrival or you may return your paperwork ahead of time.

Enclosed you will find:

1. An Adult /Child Registration form for you to fill out to assure our information is correct.
2. A pre-anesthesia questionnaire to assist your anesthesiologist in your care.
3. Medication reconciliation list, please let us know what medications you are taking, including over the counter drugs and any kind of vitamin/herbal supplements.
4. Consent to Treatment & Release of Medical Information-this allows us to provide treatment to you, and to release information to your insurance company to assist them in paying your claim.
5. Patient Consent to Resuscitative Measures-In the event of an unforeseen incident, it is our policy to administer life saving treatment to our patients until they are transferred to an acute care hospital, please check one of the boxes letting us know if you have an Advance Directive or not.
6. Privacy Notice- This notice explains our commitment to the privacy of our patient's information.
7. Patient Bill of Rights- This explains your rights as a patient.
8. Reducing your risk of infection-Please read in order to understand how to reduce the likelihood of infection.

Please bring a photo I.D. and your insurance card to the center upon registration.

If you have any questions, please call 951-849-3511.

You may fax these forms to 951-849-3513.

Thank you for your time and we hope your experience here is a positive one.

Sincerely,

Pat Finley

Pat Finley RN, Administrator

# HIGHLAND SPRINGS SURGICAL CENTER ADULT REGISTRATION

☐ I HAVE RECEIVED A COPY OF PATIENT RIGHTS & FACILITY OWNERSHIP - INITIAL-_____

**FIRST NAME:** _____ **INITIAL:** _____ **LAST:** _____ **DOB:** _____

RACE/ETHNICITY: ☐AMERICAN ☐ASIAN ☐AFRICAN AMERICAN ☐CAUCASION ☐HISPANIC ☐PACIFIC ISLANDER

**LOCAL ADDRESS**_____ CITY_____
STATE_____ZIP_____

LOCAL PHONE_____ CELL_____ SOC SECURITY: _____

**OTHER ADDRESS**_____ CITY_____

STATE_____ ZIP_____

**EMPLOYER'S NAME** _____ADDRESS_____

TELEPHONE _____

**SPOUSE'S FIRST NAME** _____LAST_____

**SPOUSE'S EMPLOYER NAME** _____ PHONE _____

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**#1- PRIMARY INSURANCE**_____ ☐HMO ☐PPO ☐OTHER_____

ADDRESS_____ CITY_____ STATE_____

**INSURED CARD HOLDER**_____**SS#**_____

**DOB**_____**ID#**_____**Group#**_____

**#2-SECONDARY INSURANCE**_____☐HMO ☐PPO ☐OTHER_____

ADDRESS_____ CITY_____ STATE_____

**INSURED CARD HOLDER**_____ SS#_____

DOB_____ ID#_____ GROUP# _____

IS THIS ACCIDENT RELATED ☐YES ☐NO IF YES, DATE OF INJURY _____

**NEAREST RELATIVE *NOT* LIVING WITH YOU**_____

ADDRESS_____ CITY_____ STATE_____

TELEPHONE _____

**PRIMARY PHYSICIAN'S NAME** _____ PHONE_____

**PATIENT SIGNATURE**_____ **DATE**_____

# HIGHLAND SPRINGS SURGICAL CENTER CHILD REGISTRATION

☐ I HAVE RECEIVED A COPY OF PATIENT RIGHTS & FACILITY OWNERSHIP - INITIAL-_____

**FIRST NAME**: _____ **INITIAL:** _____ **LAST**: _____ **DOB**: _____

RACE/ETHNICITY: ☐AMERICAN ☐ASIAN ☐AFRICAN AMERICAN ☐CAUCASION ☐HISPANIC ☐PACIFIC ISLANDER

**LOCAL ADDRESS**_____ CITY_____
STATE_____ZIP_____

LOCAL PHONE_____ CELL_____ SOC SECURITY: _____

**OTHER ADDRESS**_____ CITY_____

STATE_____ ZIP_____

**FATHER'S FULL NAME** _____ DOB_____

EMPLOYER NAME _____ PHONE _____
ADDRESS_____

**MOTHER'S FULL NAME** _____ DOB_____

EMPLOYER NAME _____ PHONE _____
ADDRESS_____

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**#1- PRIMARY INSURANCE**_____ ☐HMO ☐PPO ☐OTHER_____

ADDRESS_____ CITY_____ STATE_____

**#2-SECONDARY INSURANCE**_____☐HMO ☐PPO ☐OTHER_____

ADDRESS_____ CITY_____ STATE_____

**INSURED CARD HOLDER**_____ SS#_____

DOB_____ ID#_____ GROUP# _____

IS THIS ACCIDENT RELATED ☐YES ☐NO IF YES, DATE OF INJURY _____

**NEAREST RELATIVE *NOT* LIVING WITH YOU**_____

ADDRESS_____ CITY_____ STATE_____

TELEPHONE _____

**PRIMARY PHYSICIAN'S NAME** _____ PHONE_____

**PATIENT SIGNATURE** _____ **DATE**_____

# HIGHLAND SPRINGS SURGICAL CENTER
# PRE-ANESTHESIA QUESTIONNAIRE

Please read and fill out carefully. All information is confidential. Your anesthesiologist will use this information to help plan your anesthesia.

1. Please state your: AGE _____ WEIGHT _____ HEIGHT _____ SEX _____
2. Have you ever had an illness such as the following? _____YES _____NO

| | | |
|---|---|---|
| _____YEAR | _____YEAR | _____YEAR |
| _____Asthma | _____Hepatitis | _____Bleeding Disorder |
| _____Chronic Bronchitis | _____Jaundice | _____Sickle Cell Disease |
| _____Emphysema | _____Kidney Disease | _____Hemophilia |
| _____Tuberculosis | _____Seizures | _____Easy Bruising |
| _____High Blood Pressure | _____Epilepsy | _____Muscle Disease |
| _____Diabetes | _____Stroke | _____Arthritis |
| _____Thyroid Disease | _____Sleep Apnea | _____ |

_____Other_____

3. Have you ever had a heart attack, heart irregularity or palpitations? _____YES _____NO
   Do you get shortness of breath with light work? _____YES _____NO
   Do you awaken from sleep because you snore or cannot breathe? _____YES _____NO
   Have you been told you have sleep apnea? _____YES _____NO
   Do you sleep with two or more pillows to be able to breathe? _____YES _____NO
4. Do you have contact lenses, dentures, partial plates, capped teeth or loose teeth? _____YES _____NO
5. Have you ever had minor or major surgery? _____YES _____NO
   Please list procedure and year _____
   _____
   _____
6. If you have had surgery before, did you have any anesthesia problems such as high fever (malignant hyperthermia), prolonged muscle weakness or breathing problems? _____YES _____NO
   Explain _____
   _____
7. Are you allergic to any medications? _____YES _____NO
   Please list _____
8. Do you smoke? _____YES _____NO
   _____# packs a day _____# years _____# years quit
9. Have you had a cough or fever in the last three days? _____YES _____NO
10. If you are a woman, is there a possibility you are pregnant? _____YES _____NO
11. Are your immunizations current? _____YES _____NO

**Latex Allergy:**

**Have you ever reacted to:**

| | |
|---|---|
| Poinsettia plant | ____Yes____ No |
| Ballons | ____Yes ____No |
| Rubber Products/Gloves | ____Yes ____No |
| Clothing with elastic | ____Yes ____No |

**Have you ever reacted after eating:**

| | |
|---|---|
| Avocados | ____Yes____ No |
| Bananas | ____Yes____ No |
| Tropical fruit – Kiwi, Papayas | ____Yes____No |
| Chestnuts | ____Yes____No |

**Have you ever had any of these symptoms after a dental appointment?**

| | |
|---|---|
| Itching | ____Yes ____No |
| Tearing | ____Yes ____No |
| Fatigue/drowsy | ____Yes ____No |
| Sneezing | ____Yes ____No |
| Facial swelling/ redness | ____Yes ____No |

**Have you ever had** ____Yes ____No **problems wearing latex gloves?**

**Patient Signature** _____

Date & Time

# HIGHLAND SPRINGS SURGICAL CENTER
# MEDICATION RECONCILIATION LIST

**ALLERGIES**

| Allergies/sensitivities | Type of Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**MEDICATIONS**

| **NAME OF MEDICATION (INCLUDE OVER THE COUNTER MEDICAITONS, VITAMINS AND HERBAL SUPPLEMENTS** | **DOSE-FREQUENCY-ROUTE (SHOT, PILL, INHALER, SUPPOSITORY, EYE DROPS, TOPICAL)** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

(Please notify the nurse if you are on blood thinners and when you stopped taking them)

**NEWLY PRESCRIBED MEDICATION (For office use only)**

| NAME OF MEDICATION | DOSE - FREQUENCY |
|---|---|
| | |
| | |
| | |

**Please have your pharmacist review this list for compatibility**

Pre-Op RN Reviewing List:_____ Date/Time:_____

PACU RN Reviewing List:_____ Date/Time:_____

Patient Identification Label

HIGHLAND SPRINGS
SURGICAL CENTER

# CONSENT TO TREATMENT & RELEASE OF MEDICAL INFORMATION

A. **Consent to Treatment** - I consent to treatment by my doctor, Highland Springs Surgical Center (HSSC), its employees, and all other persons caring for me. I understand that this care may include tests, examinations, and medical and surgical treatment. I also understand that HSSC participates in teaching programs for health care professionals and I consent to treatment and observation by such professionals under the supervision and instruction of physicians or HSSC's staff or employees. I acknowledge that no assurances have been made to me regarding the result of any examination or treatment received by me.

B. **Consent to Release Medical Information** - I hereby authorize HSSC to disclose all or any part of my medical information to (A) any person or entity that may be responsible for payment of charges associated with my medical care, including but not limited to, insurance companies, governmental payers such as Medicare or Medicaid, workers' compensation carriers, and welfare funds; (B) any person or facility that is currently involved in my care, such as physicians and nurses, and any facility that may be involved in the continuum of my care, such as a nursing home to which I am being transferred, a home health agency, or a durable medical equipment provider; (C) my employer if my injury is work-related; (D) any person or entity that may process or collect a claim for payment, such as a billing company or collection agency; (E) HSSC's legal counsel in any matter to which such information is relevant and necessary; (F) persons, committees, or entities performing audits or analyzing patient medical information for quality of care, peer review, financial or compliance purposes; (G) researchers for medical research purposes; (H) family members or certain friends directly involved in my care; (I) my personal representative, such as a durable power of attorney for health care or administrator; (J) clergy; (K) companies that provide services for HSSC and, in doing so, will have access to patient health information; and (L) an attorney or law enforcement personnel pursuant to a subpoena.

C. **Drug and Alcohol Abuse Records** - I authorize my doctor, , and its agents or employees to disclose my medical information pertaining to the treatment of alcohol or drug abuse and any supporting documentation as compiled in my medical records to any person or entity for payment or treatment purposes. My consent will automatically expire after sixty (60) days from the date indicated in this section, or when it is no longer needed for the reasons stated above, whichever is later. I understand that I can revoke my consent at any time but cannot stop the information that was already given out from being used.

D. **Assignment of Insurance Benefits** - I hereby assign any and all benefits, including major medical, that are payable to the patient or to the undersigned, for payment of medical care and treatment during this treatment rendered at HSSC. The patient or the undersigned insured is responsible for charges not covered by the assignment. Should the account be referred to any attorney or collection agency for collection, the undersigned shall be responsible for any reasonable attorneys' fees and collection expense in addition to the amount being collected. **In addition to receiving a bill from HSSC, you will receive a bill from your surgeon, anesthesiologist and in some cases a bill for lab services, (pathology).**

**My signature below certifies that I have read and understand the contents of this Consent Form and that any questions I had were clarified for me before I signed it.**

_____ **Date:** _____

**Patient or legal representative**

E. **Acknowledgment of Receipt of Notice of Privacy Practices** - I acknowledge that HSSC has provided me with a copy of its Notice of Privacy Practices.

_____ **Date:** _____

**Patient or legal representative**

# Highland Springs Surgical Center

## Patient Consent to Resuscitative Measures

*(Not a Revocation of Your Advance Directives or Medical Powers of Attorney)*

All patients have the right to participate in their own healthcare decisions and to make Advanced Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based upon the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Highland Springs Surgical Center respects and upholds those rights.

However, unlike in an acute care hospital setting, the Surgical Center does not perform any "high risk" procedures. The vast majority of all procedures performed in this facility are considered to be of minimal risk and many are elective. Our staff and each patient expects to return home within hours of his or her procedure fully recovered or capable of full recovery at home with minimal follow-up care.

It is our policy, regardless of the content of any Advance Directive or instructions from a Health Care Surrogate or 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 withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive or Health Care Power of Attorney.

If you do not agree to this policy, we are pleased to assist you in rescheduling your procedure.

Please check the appropriate box in answer to these questions.

Have you executed an Advance Health Care Directive, a Living Will or a Power of Attorney that authorizes someone to make Health Care Decisions for you?

- ☐ Yes, I have an Advance Directive or Healthcare Power of Attorney
- ☐ No, I do not have an Advance Directive or Healthcare Power of Attorney
- ☐ I would like to have information on the Advance Directive

If you answered "yes" to the first question above, please provide us with a copy of that document so that it may be made a part of your medical record.

By signing this document, I acknowledge that I have read and understand its content and agree to the policy as described. If I have indicated I would like additional information, I acknowledge receipt of that information.

By: _____ _____
Patient's Signature Date

By: _____ _____
Authorized Person Date

Witness: _____ _____
Date

Dear Patient,

It is the policy of the Highland Springs Surgical Center to not honor the stipulations of an Advanced Directive/Living Will. If you choose to proceed with having your procedure performed at the center, it is with the understanding that treatment will be provided to you if you were to develop a disruption of your heart rhythm or breathing or any other complication.

If you do have an Advanced Directive or Living Will and wish to provide us with a copy of the document, we will place a copy in your medical record. In the event a transfer to a hospital is required, a copy will be forwarded to the hospital.

If you do not have an Advanced Directive/Living Will and wish to create one you may refer to one of the following:

*www.willsofamerica.com*
*www.legalzoom.com*
*www.lawinfo.com*
www.ag.ca.gov/consumers/pdf/ProbateCodeAdvancedHealthCareDirectiveForm

If you would like a copy of the State of California's official Advanced Directives form, please ask when you arrive at the center and a copy will be provided to you.

Please contact us if you have any questions (951) 849-3511.

Thank you!

# HIGHLAND SPRINGS SURGICAL CENTER

## Reduce Your Risk of Infection Before an Ambulatory Surgery/Procedure

The Association for Professionals in Infection Control and Epidemiology (APIC) offers this advice for prospective patients who are about to have a surgical procedure:

- Shower or cleanse your surgical site with an antimicrobial soap the night before or the morning of your surgery
- Do NOT shave the area where you are having surgery
- If diabetic, maintain blood glucose control during and for two days after surgery
- Stop smoking. This will reduce your chances of developing an infection after surgery
- Practice good hand hygiene after using the bathroom, before eating, after shaking hands, after blowing your nose, and before and after touching the bandage on your surgical incision

Post-Procedure

Make sure you receive instructions for wound care. Contact your doctor right away if:

- The skin around your wound gets red and/or sore, or it feels hot and swollen
- Your wound has a green or yellow colored discharge (pus)
- You feel generally unwell or feverish, or you have a temperature greater than $101^{o}$

The mission of Highland Springs Surgical Center is to continuously improve all processes. This continuous evaluation of our processes will provide our patients and the community with high quality ambulatory health care service in a therapeutic environment in a fiscally responsible manner.

# HIGHLAND SPRINGS SURGICAL CENTER

## PRIVACY NOTICE

## 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.

**Patient Health Information**
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing, and insurance information.

**How We Use Your Patient Health Information**
We use health information about you for treatment, to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

**Examples of Treatment, Payment and Health Care Operations**
*Treatment:* We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care. *Payment:* We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. *Health Care Operations:* We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

**Special Uses**
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Other Uses and Disclosures**
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
*Required by Law:* We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
*Research:* We may use or disclose information for approved medical research.
*Public Health Activities:* As required by law, we may disclose vital statistics, diseases, information related to recalls or dangerous products and similar information to public health authorities.
*Health oversight:* We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities.
*Judicial and administrative proceedings:* We may disclose information in response to an appropriate subpoena or court order.
*Law enforcement purposes:* Subject to certain restrictions, we may disclose information required by law enforcement officials.
*Deaths:* We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies.
*Serious threat to health or safety:* We may use or disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
*Military and Special Government Functions:* If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
*Workers Compensation:* We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

**Individual Rights**
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
*Inspect and Obtain Copies:* In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
*Request Restrictions:* You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
*Request of Amended Information:* If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
*Accounting of Disclosures:* :You may request a list of instances where we have disclosed health info about you for reasons other than treatment, payment or health care operations.

**Our Duty**
We are required by law to protect and maintain the privacy of your health info, to provide this Notice about our legal duties and privacy practices regarding protected health info and to abide by the terms of the Notice currently in effect.

**Changes in Privacy Practices**
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more info about our privacy practices, contact the person listed below.

**Complaints**
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

**Contact Person**
If you have any questions, requests or complaints, please contact:

Attention: Privacy Officer
Highland Springs Surgical Center
81 Highland Springs Ave Ste. 100
Beaumont, CA 92223

**Effective Date: January 2004**

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices given to me.
Signed: _____ Date: _____

## Highland Springs Surgical Center

## Patient Bill of Rights

A patient shall have the right to:

1. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status, or the source of payment for care.
2. Considerate and respectful care.
3. Knowledge of the name of the physician who has primary responsibility for coordinating the care and the names and professional relationships of other physicians and non-physicians who will see the patient.
4. Receive information from his physician about his illness, his course of treatment and his prospects for recovery in terms that he can understand.
5. Receive as much information about any proposed treatment or procedure as he may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in his treatment, alternative course of treatment or non-treatment and the risks involved in each, and to know the name of the person who will carry out the procedure or treatment.
6. Participate actively in decisions regarding his medical care. To the extent permitted by law, this includes the right to refuse treatment.
7. Full consideration of privacy concerning his medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to their reason for the presence of any individual and must consent in writing to their presence.
8. Confidential treatment of all communications and records pertaining to his care and his stay in the Surgical Center. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with his care.
9. Reasonable responses to any reasonable requests made for service.
10. Leave the Surgical Center even against the advice of his physician.
11. Reasonable continuity of care and to know in advance the time and location of appointments as well as the persons providing the care.
12. Be advised if the Surgical Center or personal physician proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.
13. Be informed of his continuing health care requirements following discharge from the Surgical Center.
14. Examine and receive an explanation of his/her bill regardless of source of payment.
15. Know which Surgical Center rules and policies apply to the patient's conduct while a patient.
16. Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
17. Designate visitors of his/her choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
    A. No visitors are allowed.
    B. The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
    C. The patient has indicated to the health facility staff that the patient no longer wants this person to visit.

# HIGHLAND SPRINGS SURGICAL CENTER

## PRACTICAS DE PRIVACIDAD

**ESTE AVISO DESCUBRE COMO LA INFORMACION MEDICA DE USTE PUEDE SER USADA Y DIVULGADA Y COMO PUEDE HAGARA ACCESO A ESTA INFORMACION. PORFAVOR DE REVISELA CON CUIDADO.**

- **Informacion De Salud Para El Paciente**
  Debajo de la Ley Federal, su informacion de salud es cuidada y confidencial. Informacion De La Salud Del Paciente incluye informacion de sus sintomas, resultados de pruebas, diagnosticos, tratamientos y cualquier tratamiento relasionado con informacion de salud. Su Informacion de Salud tambien incluye pagos, bil, y informacion de aseguranza.
- **Como Usamos Su Informacion De Salud**
  Usamos informacion de usted para el tratamiento, para obtener pagos y para operaciones de cuidado de salud, incluyendo efectos administrativos y evaluacion de la cualidad del cuidado que a resibido. Debajo de algunas circunstancias, podriamos requerir de usar o revelar la informacion incluso sin su permiso.
- **Ejemplos Del Tratamiento, Pagos y Operaciones De Cuidado De Salud**
  *Tratamiento*: Usaremos y revelaremos su informacion de Salud para proporsionarle servicios medicos. Por ejemplo , enfermeras, medicos, y otros miembros de su grupo de tratamiento podran registrar informacion en su recor y usarlo para determinar el mas apropiado curso de cuidado. Tambien podriamos revelar la informacion a otros proveedores de servicios de salud que participen en su tratamiento, para farmaceuticos que estan llenando su prescripcion, y a miembros de la familia que esten ayudando con su cuidado. *Pagso:* Vamos a utilizar y divulgar su informacion de salud para propositos de pagos. Por ejemplo, posiblemente puedamos necesitar de obtener autorisacion de su aseguranza de conpania antes de empesar cualquier tratamiento. Vamos a presentar biles y mantener registros de pagos de su plan de salud. *Operaciones de cuidado de salud:* Usaremos y revelaremos su informacion para una conducta de nuestra estandar interiores de operaciones, incluyendo adecuada administracion de recor, evaluacion de la cualidad de tratamiento, y para evualar el cuidado y resultados de su caso y otros como estos.
- **Usos Especiales:** Nosotros podemos usar su informacion para contactarlo antes du se cita. Ademas, para informarle acerca de tratamientos alternativos o otros beneficios medicos relacionados a su caso servicios que le puedan interesar y beneficiar.
- **Otros Usos y Revelaciones:** Podemos usar y revelar informacion medica especifica de usted por otras razones, aun sin su consentimiento. Tema a siertos requisitos, estamos permitidos a dar informacion medica sin su permiso para los siguientes motivos: *Requerido Por La Ley:* Que puede ser requerido por la ley de reportar heridas de pistolas, sospechas de abuso, o negledad o similares heridas o eventos. Investigacion: Podriamos usar o revelar informacion para investigaciones aprovadas para uso medico. *La salud publica de actividades:* Como requerido por la ley, podriamos revelar statisticas vitales , enfermedades, informacion relacionada con cosas pasadas o productos peligrosos y informacion similar para las autoridades de salud publica. *Supervision de la salud:* Podemos requerir que revelemos informacion para asistir en envistigaciones y auditorios, elgibilidad para los programas de gobierno y actividades similares.*Los Procedimientos Judiciales y Administrativos:* Podemos revelar informacion en respuesta a una apropiada citacion o orden judicial. *La Aplicacion De La Ley De Servicios:* Sujeto a ciertas restricciones, podemos revelar informacion requerida por la ley oficiales enforsados. *Muertes:* Podemos reportar informacion sobre muertes a forenses, examinadores medicos, directores de funeraria, y agencias de donacion de organos.Grave *amenaza para la salud o la seguridad:* Podemos usar o revelar informacion cuando sea necesario para prevenir una seria amenaza para su salud y seguridad o la seguridad y salud del public o otras personas.*Funciones Militarias y Especialidades del-*

# HIGHLAND SPRINGS SURGICAL CENTER

**Carta De Derechos De Los Pacientes**

El Paciente tiene el derecho a:

1. Ejercitar estos derechos sin considerar sexo, situación económica, antecedentes educativos, raza, color, religión, abolengo, origen, orientación sexual, estado civil, o la fuente de pago del cuidado.
2. Cuidado respetoso y considerado.
3. Conocimiento del nombre de su medico quien tiene la primaria responsabilidad de la coordinacion de la atencion y los nombres y relaciones profesionales de los medicos y medicos que no son medicos quienes atenderan a los pacientes.
4. Recibir informacion de su medico sobre su enfermedad, su clase de tratamiento y su respectivas de recuperacion en terminos que puedan ser conprendidos.
5. Recibir la mayor informacion sobre su propuesta de tratamiento o procedimiento ya que puede necesitar para dar su consentimiento o para negarse para este curso de tratamiento. Exepto en casos de urgencia, esta informacion debe de incluir una descripcion del procedimiento o tratamiento y los riesgos que incluyen en cada uno, y de saber el nombre de la persona que cargara el procedimiento o tratamiento.
6. Participar actualmente en deciciones sobre su estado de salud. Al extremo permitido por la ley, esto incluye el derecho de rechazar tratamiento.
7. Plena consideracion de privacidad en relacion a su programa de cuidad de salud. Caso discutido, consulta, examinacion y tratamiento son confidenciales y deben condusirse discretamente. El paciente tiene el derecho de ser avisado de la presencia de cualquier persona individual y deben dar su consentimiento en escrito en su presencia.
8. Confidencial tratamiento de toda comunicacion y records perteniendo a su cuidado y visita en el centro quirurjico. Permiso en escrito debe de ser obtenido antes que su archivo sea desponible para qualquier persona no relacionado directamente de su cuidado.
9. Razonables respuestas a qualquier servicio que sea razonable.
10. Dejar el hospital aún cuando se en cuentra del los consejos de su médico.
11. Cuidado razonable continuo y saber de antemano la fecha y lugar de las citas como también las personas que proveen el cuidado.
12. Ser avisado si el hospital/propio médico propone participar en o realizar experimentos humanos que afecten su cuidado o tratamiento. El paciente tiene a derecho de rehusarse a participar en tales proyectos de investigación.
13. Ser informado por el médico de requisitos de cuidado de la salud prolongados después de que se le haya dado de alta del hospital.
14. Revisar y recibir una explicación de la factura sin tener en cuenta la fuente de pago.
15. Tener conocimiento de cuáles reglas y políticas de Surgical Center aplican al manejo del paciente mientras es paciente.
16. Hacer que apliquen todos los derechos del paciente en la persona que podria tener responsabilidad legal para tomar decisions en relación al cuidado médico en beneficio del paciente.
17. Designar visitantes de su elección, si el paciente tiene la capacidad de tomar decisiones, ya sea que el visitante sea pariente consanguíneo o por matrimonio a menos que;
    - A. No se admitan visitas
    - B. El establecimiento determine razonablemente que la presencia de un visitante en particular pondría en peligro la salud o seguridad del paciente, de algún miembro del personal del establecimiento de salud o de otro visitante del establecimiento de salud, o interrumpiría de manera significativa las operaciones del establecimiento.
    - C. El paciente ha indicado al personal del establecimiento de salud que ya no desea la visita de esta persona.