

## Jacksonville Surgery Center

904.281.0021

### PATIENT NOTIFICATION

#### **DISCLOSURE OF OWNERSHIP**

- Physician does** have a financial interest in this facility.
- Physician does not** have a financial interest in this facility.

#### **Medical Malpractice Coverage:**

Your physician may not carry malpractice coverage. If you have questions about malpractice coverage, please discuss those with your physician.

#### **PATIENT RIGHTS:**

- The patient has the right to be informed of his/her rights in advance of, receiving care. The patient may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex, cultural, economic, education, religious background, physical handicap, or the source of payment for care.
- Considerate, respectful and dignified care, provided in a safe environment, with protection of privacy, free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see them. The patient has a right to request a change in providers if other qualified providers are available.
- Be advised if the physician has a financial interest in the surgery center.
- Be advised as to the absence of malpractice coverage.
- Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes), and prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Be informed of the facility's policy and state regulations regarding advance directives and be provided advance directive forms if requested.
- Receive a copy of a clear and understandable itemized bill and receive an explanation of his/her bill regardless of source of payment.
- Receive upon request, full information and necessary counseling on the availability of known financial resource for his /her care, including information regarding facilities discount and charity policies.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his /her health care.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility. His/her written permission will be obtained before medical records can be made available to anyone not directly concerned with their care.
- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his/her medical record within a reasonable time frame.
- Be advised of the facility's grievance process, should he/she wish to communicate a concern regarding the quality of the care they received. Notification of the grievance process includes: whom to contact to file a grievance, and that he/she will be provided with a written notice of the grievance determination that contains the name of the facility's contact person, the steps taken on his/her behalf to investigate the grievance, the results of the grievance and the grievance completion date.
- Be advised of contact information for the state agency to which complaints can be reported, as well as contact information for the Office of the Medicare Beneficiary Ombudsman.
- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting their care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trails. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided it subjects will be contained in the medial record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate of thereof of the continuing healthcare requirement following their discharge from the facility.
- Be informed if Medicare eligible, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive upon request, prior to treatment, a reasonable estimate of charges for medical care.

#### **PATIENT RESPONSIBILITIES:**

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over the counter products and dietary supplements), allergies and sensitivities and other matters relating to his/her health.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.

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- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- The patient is responsible for reporting to the health care provider any unexpected changes in his/her condition.
- Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours unless exempted from that requirement by the attending physician.
- In the case of pediatric patients, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.
- The patient is responsible for his/her actions should you refuse treatment or not follow your physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible to inform the facility about the patient's advance directives.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.

**ADVANCE DIRECTIVE NOTIFICATION:**

In the state of Florida, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. The Jacksonville Surgery Center respects and upholds those rights.

However, unlike in an acute care hospital setting, the Surgery Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after surgery.

Therefore, it is our policy, regardless of the contents 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 treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Healthcare Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you wish to complete an Advance Directive, copies of the official state forms are available at our facility or may obtain a copy via the website:

[http://ahca.myflorida.com/mchq/health\\_facility\\_regulation/HC\\_Advance\\_Directives/index.shtml](http://ahca.myflorida.com/mchq/health_facility_regulation/HC_Advance_Directives/index.shtml)

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

If a patient is adjudged incompetent under the states laws, the rights of the patient are exercised by the person appointed and /or the legal representative designated by the patient under Florida law to act on the patient's behalf. The center will accept a Court Appointed Guardian, Dual Power of Attorney, or a Health Care Surrogate.

**PATIENT COMPLAINT OR GRIEVANCE**

- If you have a problem or complaint, please speak to the receptionist or your care giver. We will address your concern(s) promptly.
- If necessary, your problem or complaint will be advanced to the Administrator and/or Quality Assurance Coordinator for resolution. You will receive a letter or phone call to inform you of the actions taken to address your complaint.
- If you are not satisfied with the response of the Surgery Center, you may contact:

Patient complaints or grievances may be filed through the State of Florida Consumer Services Unit at 1-888-419-3456 (Press 2) or write to the address below:

Complaints against an ambulatory surgical center may be filed with the state of Florida by calling the Consumer Assistance Unit at 1-888-419-3456 or write to:

**Agency for Health Care Administration  
Consumer Assistance Unit  
2727 Mahan Drive / BLDG. 1  
Tallahassee, Florida 32308**

If you have a complaint against a health care professional and want to receive a complaint form, call Consumer Services Unit at 1-888-419-3456 (Press 2) or write to the address below:

**Department Of Health  
Consumer Services Unit  
4052 Bald Cypress Way, Bin C75  
Tallahassee, Florida 32399-3275**

You may also contact AAAHC by mail at:

**Accreditation Association for  
Ambulatory Health Care, INC.  
5250 Old Orchard Road, Suite 200  
Skokie, Illinois 60077**

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman's webpage on the web at:

[www.cms.hhs.gov/center/ombudsman](http://www.cms.hhs.gov/center/ombudsman)

**BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS:**

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient /Patient Representative Signature)