Foundation Surgical Hospital
of El Paso
1416 George Dieter, El Paso, TX 79936

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

1. **Purpose:** The Facility and its professional staff, employees, and volunteers and all of its affiliated entities of Foundation Surgical Hospital of El Paso (referred to collectively as Facility) follow the privacy practices described in this Notice. The Facility maintains your medical information in records that will be maintained in a confidential manner, as required by law. However, the Facility must use and disclose your medical information to the extent necessary to provide you with quality health care. To do this, the Facility must share your medical information as necessary for treatment, payment and health care operations.
2. **What Are Treatment, Payment, and Health Care Operations?** Treatment includes sharing information among health care providers involved in your care. For example, your physician may share information abut your condition with the pharmacist to discuss appropriate medications or with radiologists or other consultants in order to make a diagnosis. The Facility may use your medical information as required by your insurer or HMO to obtain payment for your treatment and facility stay. We also may use and disclose your medical information to improve the quality of care, *e.g.*, for review and training purposes.
3. **How Will the Facility Use My Medical Information?** Your medical information may be used, unless you ask for restrictions on a specific use or disclosure, for the following purposes:
   - Facility Directory, which may include your name, general condition, and your location in the Facility.
   - Religious affiliation to a facility chaplain or member of the clergy.
   - Family members or close friends involved in your care or payment for your treatment.
   - Disaster relief agency if you are involved in a disaster relief effort.
   - Appointment reminders.
   - To inform you of treatment alternatives or benefits or services related to your health. (You will have an opportunity to refuse to receive this information.)
   - Fundraising activities by the Facility's Foundation, but such information will be limited to your name, address, phone number, and the dates you received services at the Facility. (You will have an opportunity to refuse to receive these communications.)
   - As required by law.
   - Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence (if you agree or as required by law).
   - Health oversight activities, *e.g.*, audits, inspections, investigations, and licensure.
   - Lawsuits and disputes. (We will attempt to provide you advance notice of a subpoena before disclosing the information.)
   - Law enforcement (*e.g.*, in response to a court order or other legal process; to identify or locate an individual being sought by authorities; about the victim or a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred on the Facility's premises; and in emergency circumstances relating to reporting information about a crime.)
   - Coroners, medical examiners, and funeral directors.
   - Organ and tissue donation.
   - Certain research projects.
   - To prevent a serious threat to health or safety.
   - To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
   - National security and intelligence activities.
   - Protection of the President or other authorized persons for foreign heads of stat, or to conduct special investigations.
   - Inmates. (medical information about inmates or correctional institutions may be released to the institution.)

- Workers' Compensation. (Your medical information regarding benefits for work-related illnesses may be released as appropriate.)
- To carry out health care treatment, payment, and operations functions through business associates, *e.g.*, to instal a new computer system.

4. **Your Authorization Is Required for Other Disclosures.** Except as described above, we will not use or disclose your medical information unless you authorize (permit) the Facility in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.
5. **You Have Rights Regarding Your Medical Information.** You have the following rights regarding your medical information, provided that you make a written request to invoke the right on the form provided by the Facility:
   - **Right to request restriction.** Your may request limitations on your medical information we use or disclose for health care treatment, payment, or operations (*e.g.*, you may ask us not to disclose that you have had a particular surgery), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
   - **Right to confidential communications.** You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.
   - **Right to inspect and copy.** You have the right to inspect and copy your medical information regarding decisions abut your care; however, psychotherapy notes may not be inspected and copied. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by the Facility. The Facility will comply with the outcome of the review.
   - **Right to request amendment.** If you believe that the medical information we have about you is incorrect or incomplete, you may request an amendment on the form provided by the Facility, which requires certain specific information. The Facility is not required to accept the amendment.
   - **Right to accounting of disclosures.** You may request a list of the disclosures of your medical information that have been made to persons or entities other than for health care treatment payment or operations in the past six (6) years, but not prior to April 14, 2003. After the first request, there may be a charge.
   - **Right to a copy of the Notice.** You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice at our web site, <http://www.foundationsurgery.com>.
6. **Requirements Regarding This Notice.** The Facility is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. The Facility may change this Notice and these changes will be effective for medical information we have about you as well as any information we receive in the future. Each time you register at the Facility for health care services as an inpatient or outpatient, you may receive a copy of the Notice in effect at the time.
7. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Facility, Corporate Complaint Hotline, or with the Secretary of the United States Department of Health and Human Services @ www.hhs.gov/ocr/hipaa. *You will not be penalized or retaliated against in any way for making a complaint to the Facility or the Department of Health and Human Services.*

Contact: Call the Administrator or Privacy Officer, at (915) 598-4240

- You have a complaint;
- You have any questions about this Notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- You wish to obtain a form to exercise your individual rights described in paragraph 5.

Corporate Compliance Hotline Number is
1-877-874-8415

Patient Acknowlegement of Receipt:

Patient Signature: ______________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________

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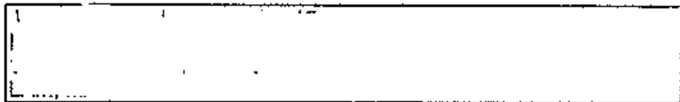

CONSENT FOR ADMISSION & TREATMENT

TO MEDICAL CARE: I request admission to FOUNDATION SURGICAL HOSPITAL of EL PASO and authorize the facility, staff and physicians to provide care. I request and consent to medical care and diagnostic procedures that my attending physician(s), or his/her designees, determine are necessary. I acknowledge that the medical care I receive while in FOUNDATION SURGICAL HOSPITAL of EL PASO is under the direction of my attending physician(s) and that FOUNDATION SURGICAL HOSPITAL of EL PASO is not responsible for acts of omission of my attending physician(s). I authorize FOUNDATION SURGICAL HOSPITAL of EL PASO to retain or dispose of any specimen or tissue taken from the above named patient.

TEACHING PROGRAMS: I understand that this FOUNDATION SURGICAL HOSPITAL of EL PASO is a facility that promotes education opportunities, and therefore, I understand that I may be seen and examined by supervised participants as a part of the educational program. I agree to participate in these programs, but reserve the right to limit my participation at any time.

DISCLOSURE OF INFORMATION: The undersigned agrees that all records concerning this patient's hospitalization shall remain the property of the facility. The undersigned understands that medical records and billing information generated or maintained by the facility are accessible to facility personnel and medical staff. Facility personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care for this admission. The facility is authorized to disclose all or part of the patient's medical record to any insurance company, third party payor, workers compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of patient's account. Law requires that the facility advise the undersigned that THE INFORMATION RELEASED MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosers.

SPECIAL CONSENT FOR HIV TESTING: the undersigned specifically consents to the testing of the patient's blood or human immunodeficiency virus (also known as AIDS) and/or Hepatitis if determined by the patient's attending physician to be necessary (i) for determining the appropriate treatment and/or treatment procedures for the patient or (ii) for the protection of the attending physician and/or any employee or agent of the facility or the attending physician exposed to the bodily fluids of the patient in a manner which could transmit such disease. The undersigned has been informed about the nature of the blood test, its expected benefit, and has been given the opportunity to ask questions about the blood test.

☐ Yes ☐ No _______ (Initials) I (we) authorize FOUNDATION SURGICAL HOSPITAL of EL PASO and/or my physician and/or physicians to photograph/video or permit other persons to photograph/video for such purposes as may be deemed necessary.
☐ Yes ☐ No _______ (Initials) I (we) consent to the presence of students, residents or fellows, and vendors in the operating room to observe the procedures. I am aware that only the physician may grant this permission on my consent.

ADVANCE DIRECTIVE AND ORGAN TISSUE DONOR: The patient, or his/her representative, hereby acknowledges having been provided with information regarding patient rights and patient's right to prepare an advance directive. The following have been executed:

Advance Directive and/or Living Will	☐ Yes	☐ No	_______ (Initials)
Would you like more information on Advance Directives?	☐ Yes	☐ No	_______ (Initials)
Medical Durable Power of Attorney	☐ Yes	☐ No	_______ (Initials)
Have you received a copy of the Bill of Rights?	☐ Yes	☐ No	_______ (Initials)
Do you have a legal guardian?	☐ Yes	☐ No	_______ (Initials)

Please provide name: ______________________________

PATIENT RIGHTS AND RESPONSIBILITIES: By signing below, I acknowledge receipt of information explaining my rights as a patient and, I received a copy of the State notice and this facility's Patient Rights and Responsibilities to Self-Determination.

I have been informed that my physician may be a partner in ownership of FOUNDATION SURGICAL HOSPITAL of EL PASO. I have the right to review a list of partners. They physicians and Allied Health Professionals (AHPs) practicing at FOUNDATION SURGICAL HOSPITAL of EL PASO are licensed and/or credentialed to practice in this facility. They physicians and AHPs provide medical services at FOUNDATION SURGICAL HOSPITAL of EL PASO, but they are not agents or employees of FOUNDATION SURGICAL HOSPITAL of EL PASO.

FINANCIAL AGREEMENTS: For services hereto performed or to be performed for the Patient by FOUNDATION SURGICAL HOSPITAL of EL PASO (whether one or more), below signed (severally if more than one), whether as patient, agent or guarantor, agrees and promises to pay the charges for the care so provided to the Patient by FOUNDATION SURGICAL HOSPITAL of EL PASO in accordance with FOUNDATION SURGICAL HOSPITAL's then current standard rates and all costs incurred in collecting same, together with attorney's fees, which FOUNDATION SURGICAL HOSPITAL of EL PASO deems necessary and reasonably required to enforce the rights of FOUNDATION SURGICAL HOSPITAL of EL PASO.

Patient Signature: ______________________ ______________ Date: ______________

Witness Signature: ______________________________ Date: ______________

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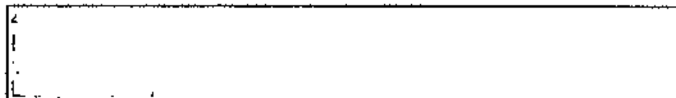

Patient Rights and Responsibilities

Patient Rights

- Patients have the right to considerate and respectful care at all times and under all circumstances with recognition of their personal dignity including freedom from abuse and harassment.
- Patients have the right under HIPAA privacy Rules to personal and informational privacy as manifested by the right to (a) Refuse to talk with or see anyone who is not officially connected with the hospital or who is not directly involved in their care; (b) Be interviewed and examined in surroundings designed to assure reasonable privacy; (c) Expect that any discussion or consultation involving their case will be conducted discreetly; (d) Have their medical records read only by individuals directly involved in their treatment or the monitoring and assessment of care; and (e) Expect all communications and other records pertaining to their care, including source of payment for treatment, to be treated as confidential.
- Patients have the right to know the identity and professional status of individuals providing service to them and to know which physician or other practitioner is primarily responsible for their care.
- Patients have the right to obtain from the practitioner responsible for coordinating their care, in terms they can reasonably be expected to understand, complete and current information concerning their diagnosis, treatments, and prognosis. When it is not medically advisable to give such information to patients, it should be made available to a legally authorized individual.
- Patients have the right to timely access of their medical records.
- Patients/families have the right to education regarding (a) pain relief measures; (b) their roles in managing pain; and (c) limitations of pain management.
- Patients have the right to reasonably informed participation indecisions involving their health care. (a) They have the right to receive from their physician information necessary to give informed consent prior to the start of any procedure and/or treatment; (b) they have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of their actions; and (c) They have the right to formulate or have an existing advance directive in their medical record. The wishes communicated by these directives will be honored.
- Patients have the right to participate in ethical questions that arise during the course of care, including issues of conflict resolution, withholding resuscitative devices, and foregoing or withdrawal of life-sustaining treatment.
- Patients have the right to freedom from restraints (physical restraints or drugs) used in the provision of medical and surgical care unless clinically necessary.
- Patients shall be informed if the hospital proposes to engage in or perform human experimentation or other research/educational projects affecting their care or treatment, and patients have the right to refuse to participate in any such activity.
- Patients may not be transferred to another facility unless they have received a complete explanation of the need for the transfer and the alternatives to such a transfer, and unless the transfer is acceptable to the other facility.
- Patients have the right to be informed by the responsible practitioner or his delegate of any continuing health care requirements following discharge from he hospital.
- Regardless of the source of payment for care, patients have the right to request and receive an itemized bill for services rendered in the hospital.
- Patients have the right to a specific grievance procedure to a Peer Review organization regarding concerns of quality of care or premature discharge.

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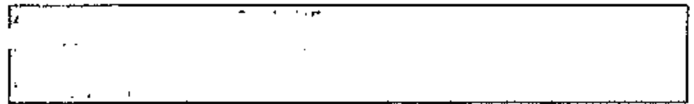

Patient Responsibilities

- Patients have the responsibility to provide accurate and complete information about current and past illnesses, medications, and other matters pertaining to their health.
- Patients have the responsibility to ask your doctor/nurse what to expect regarding pain and pain relief options, to work with your doctor/nurse in developing a pain management plan, to ask for pain relief when pain first begins, to help us measure your pain, and to tell us if your pain is not relieved.
- Patients have the responsibility to report unexpected changes in your condition to the responsible practitioner.
- Patients have the responsibility to follow the treatment plan recommended by their practitioner or express concerns regarding their ability to comply.
- Patients are responsible for their actions if they refuse treatment or do not follow the practitioner's instructions. If patients refuse to follow the treatment plan, they will be responsible for any adverse outcomes as a result of their actions.
- Patients have the responsibility to ask questions and request additional information/clarification when you do not understand your care, treatment, or services, or what is expected of you.
- Patients have the responsibility to participate in those educational and discharge planning activities necessary to ensure you have adequate knowledge and support services necessary to provide you with a safe environment upon discharge from the hospital.
- Patients have the responsibility to arrive as scheduled for appointments and to cancel in advance appointments they cannot keep.
- Patients have the responsibility to become informed of the scope of basic services offered, the costs, and the necessity for medical insurance and to actively seek clarification of any aspect of participation in hospital services and programs (including cost) that is not understood and to fulfill the financial obligations of your health care. In the case of minors or incompetent adult patients, the parents or legal guardians shall be accountable for adhering to the responsibilities listed.
- Patients have the responsibility to respect hospital property and the property of others.
- Patients have the responsibility to consider the rights of other patients and personnel of the hospital, and assist in the control of noise, smoking, and the number of visitors.
- Patients have the responsibility to provide the hospital with a copy of your advance directive, if one exists.

The physicians, nurses and the entire staff at Foundation Surgical Hospital are committed to assure you reasonable care. Should you have a complaint or grievance related to Foundation Surgical Hospital, contact the CEO at (915) 598-4240.

If your complaint or grievance is not resolved to your satisfaction,you may contact the Texas Department of Health, Health Facility Licensing & compliance Division, 1100 West 49th Street, Austin, Texas 78756, Telephone (888) 973-0022. Presentation of a complaint will not compromise your care under any circumstances.

You may also file a complaint with DNV Healthcare Inc., our accrediting agency by calling (866) 523-6842 or by sending an email message to: hospitalcomplaint@dnv.com or visit www.dnv.com for more information.

Office For Civil Rights, Department of Health and Human Services, 1301 Young Street Suite 1169, Dallas, Texas, 75202, Telephone: (214) 767-4056, Fax: (214) 767-0432, TDD: (214) 767-8940.

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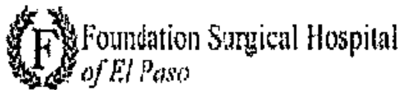

ASSIGNMENT OF BENEFITS

Assignment of Insurance Benefits to Foundation Surgical Hospital of El Paso: As or on behalf of the Insured under the Insurance specified on the registration documents of the Patient, and otherwise payable thereto (the present and future rights thereto and monies due or to become due there from termed "Contract Rights"), the below signed irrevocably assigns and transfers to Foundation Surgical Hospital of El Paso the Contract Rights, and orders and directs such insurer(s) to pay all monies due or to become due thereunder directly to Foundation Surgical Hospital of El Paso or its assignee. To effect such payment, Foundation Surgical Hospital of El Paso is irrevocably constituted and appointed lawful attorney in fact with substation power, to sue or otherwise collect and settle any claim under the Contract Rights as insured without further notice or approval of insured and to endorse in the name of the insured any check or other instrument for the payment of monies thereunder. Further, I understand that Anesthesiology, Physician Services, Pathology, Radiology and some Laboratory Service will bill me separately and assign my insurance benefits to them if their services are rendered during my treatment. I also authorize them to release my medical information needed by my insurance carrier to process the claim.

If insured receives monies directly from the Insurer(s), same shall be held in trust and immediately transferred to Foundation Surgical Hospital of El Paso for amounts due. This assignment is irrevocable with interest until full and complete payment of all monies due to the facility and its affiliates from this event of admission or otherwise. Money received by Foundation Surgical Hospital of El Paso from insurer(s) or other third party sources, less the expense in procuring same, shall be deducted from the principal amount due for services rendered to the Patient. If charges not covered by insurance cannot be paid in full when due, below signed agrees upon request to sign a promissory note bearing interest at the maximum legal rate to pay all debt not paid, if credit is approved.

Insurance Precertification: Foundation Surgical Hospital will assist in obtaining precertification for my services. However, I understand that precertification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.

Medicare Assignment, Patient's Certification, Authorization to Release Information and Payment Request:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

Acknowledgement of Notice of Privacy Practices:
A description of how your medical information will be used and disclosed is summarized on the Patient Privacy Notice. A complete copy of the Facility's Notice of Privacy Practice is included in your admission packet and posted in the Facility. By signing below you acknowledge that you have received a copy of the Facility Notice of Privacy Practice.

I Give Permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the insurance specified on the registration documents of the Patient.

I (WE), THE UNDERSIGNED, HEREBY CERTIFIY THAT I (WE) HAVE READ AND FULLY UNDERSTAND THIS CONDITION OF ADMISSION

Signature of Patient:______________________________ Date______________

Legal Guardian/Power of Attorney:______________________________ Date______________

Relationship to Patient:______________________________ Date______________

Witness: ______________________________ Date______________