SURGERY CENTER OF WASILLA

NOTICE OF PRIVACY INFORMATION 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 IT CAREFULLY.

A. PURPOSE OF THE NOTICE.

SURGERY CENTER OF WASILLA is committed to preserving the privacy and confidentiality of your health information which is created and/or maintained at our clinic. State and federal laws and regulations require us to implement policies and procedures to safeguard the privacy of your health information. This Notice will provide you with information regarding our privacy practices and applies to all of your health information created and/or maintained at our clinic, including any information that we receive from other health care providers or facilities. The Notice describes the ways in which we may use or disclose your health information and also describes your rights and our obligations concerning such uses or disclosures.

We will abide by the terms of this Notice, including any future revisions that we may make to the Notice as required or authorized by law. We reserve the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you, as well as any information we receive in the future. We will post a copy of the current Notice which will identify its effective date in our clinic.

The privacy practices described in this Notice will be followed by:

1. Any health care professional authorized to enter information into your medical record created and/or maintained at our clinic;
2. All employees, students, residents, and other service providers who have access to your health information at our clinic; and
3. Any member of a volunteer group which is allowed to help you while receiving services at our clinic.

The individuals identified above will share your health information with each other for purposes of treatment, payment and health care operations, as further described in the Notice.

B. USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

1) **Treatment, Payment and Health Care Operations.** The following section describes different ways that we may use and disclose your health information for purposes of treatment, payment, and health care operations. We explain each of these purposes below and include examples of the types of uses or disclosures that may be made for each purpose. We have not listed every type of use or disclosure, but the ways in which we use or disclose your information will fall under one of these purposes.

   a. **Treatment.** We may use your health information to provide you with health care treatment and services. We may disclose your health information to doctors, nurses, nursing assistants, medication aides, technicians, medical and nursing students, rehabilitation therapy specialists, or other personnel who are involved in your health care.

      For example, we may order physical therapy services to improve your strength and walking abilities. We will need to talk with the physical therapist so that we can coordinate services and develop a plan of care. We also may need to refer you to another health care provider to receive certain services. We will share information with that health care provider in order to coordinate your care and services.

b. **Payment**. We may use or disclose your health information so that we may bill and receive payment from you, an insurance company, or another third party for the health care services you receive from us. We also may disclose health information about you to your health plan in order to obtain prior approval for the services we provide to you, or to determine that your health plan will pay for the treatment.

For example, we may need to give health information to your health plan in order to obtain prior approval to refer you to a health care specialist, such as a neurologist or orthopedic surgeon, or to perform a diagnostic test such as a magnetic resonance imaging scan ("MRI") or a CT scan.

c. **Health Care Operations**. We may use or disclose your health information in order to perform the necessary administrative, educational, quality assurance and business functions of our clinic.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We also may use your health information to evaluate whether certain treatment or services offered by our clinic are effective. We also may disclose your health information to other physicians, nurses, technicians, or health profession students for teaching and learning purposes.

C. USES AND DISCLOSURES OF HEALTH INFORMATION IN SPECIAL SITUATIONS

1. **Appointment Reminders**. We may use or disclose your health information for purposes of contacting you to remind you of a health care appointment.

2. **Treatment Alternatives & Health-Related Products and Services**. We may use or disclose your health information for purposes of contacting you to inform you of treatment alternatives or health-related products or services that may be of interest to you. For example, if you are diagnosed with a specific condition, we may contact you to inform you of an instruction class that is offered for your condition.

3. **Family Members and Friends**. We may disclose your health information to individuals, such as family members and friends, who are involved in your care or who help pay for your care. We may make such disclosures when: (a) we have your verbal agreement to do so; (b) we make such disclosures and you do not object; or (c) we can infer from the circumstances that you would not object to such disclosures. For example, if your spouse comes into the exam room with you, we will assume that you agree to our disclosure of your information while your spouse is present in the room.

We also may disclose your health information to family members or friends in instances when you are unable to agree or object to such disclosures, provided that we feel it is in your best interests to make such disclosures and the disclosures relate to that family member or friend's involvement in your care. For example, if you present our clinic with an emergency medical condition, we may share information with the family member or friend that comes with you to our clinic. We will need written permission to share your health information with your family and friends regarding your prescription(s).

D. OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES OF HEALTH INFORMATION.

There are certain instances in which we may be required or permitted by law to use or disclose your health information without your permission. These instances are as follows:

1. **As required by law**. We may disclose your health information when required by federal, state, or local law to do so. For example, we are required by the Department of Health and Human Services (HHS) to disclose your health information in order to allow HHS to evaluate whether we are in compliance with the federal privacy regulations.

2. **Public Health Activities**. We disclose your health information to public health authorities that are authorized by law to receive and collect health information for the purpose of preventing or controlling disease, injury, or disability; to report births, deaths, suspected abuse or neglect, reactions to medications; or to facilitate product recalls.

3. **Health Oversight Activities**. We may disclose your health information to a health oversight agency that is authorized by law to conduct health oversight information to health oversight investigations, inspections, or licensure and certification surveys. These activities are necessary for the government to monitor the persons or organizations that provide health care to individuals and the government to monitor the persons or organizations that provide health care to individuals and to ensure compliance with applicable state and federal laws and regulations.

4. **Judicial or Administrative Proceedings**. We may disclose your health information to courts or administrative agencies charged with the authority to hear and resolve lawsuits or disputes. We may disclose your health information pursuant to a court order, a subpoena, a discovery request, or other lawful process issued by a judge or other person involved in the dispute, but only if efforts have been made to (i) notify you of the request for disclosure or (ii) obtain an order protecting your health information.

5. **Worker's Compensation**. We may use and disclose your protected health information for workers'
6. **Law Enforcement Official**. We may disclose your health information to a request received from a law enforcement official to report criminal activity or to respond to a subpoena, court order, warrant, summons, or similar process.

7. **Coroners, Medical Examiners, or Funeral Directors**. We may disclose your health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We also may disclose your health information to a funeral director for the purpose of carrying out his/her necessary activities.

8. **Organ Procurement Organizations or Tissue Banks**. If you are an organ donor, we may disclose your health information to organizations that handle organ procurement, transplantation, or tissue banking for the purpose of facilitating organ or tissue donation or transplantation.

9. **Research**. We may use or disclose your health information for research purposes under certain limited circumstances. Because all research projects are subject to a special approval process, we will not use or disclose your health information for research purposes until the particular research project for which your health information may be used or disclosed has been approved through this special approval process. However, we may use or disclose your health information to individuals preparing to conduct the research project in order to assist them in identifying patients with specific health care needs who may qualify to participate in the research project. Any use or disclosure of our health information which is done for the purpose of identifying qualified participants will be conducted onsite at our facility. In most instances, we will ask for your specific permission to use or disclose your health information if the researcher will have access to your name, address, or other identifying information.

10. **To Avert a Serious Threat to Health or Safety**. We may use or disclose your health information when necessary to prevent a serious threat to the health or safety of you or other individuals.

11. **Military and Veterans**. If you are a member of the armed forces, we may use or disclose your health information as required by military command authorities.

12. **National Security and Intelligence Activities**. We may use or disclose your health information to authorized federal officials for purposes of intelligence, counterintelligence, and other national security activities, as authorized by law.

13. **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclose your health information to the correctional institution or to the law enforcement official as may be necessary (i) for the institution to provide you with health care; (ii) to protect the health or safety of you or another person; or (iii) for the safety and security or the correctional institution.

E. USES AND DISCLOSURES PURSUANT TO YOUR WRITTEN AUTHORIZATION.

Except for the purposes identified above in Sections B through D, we will not use or disclose your health information for any other purposes unless we have your specific written authorization. You have the right to revoke a written authorization at any time as long as you do so in writing. If you revoke your authorization, we will no longer use or disclose your health information for the purposes identified in the authorization, except to the extent that we have already take some action in reliance upon your authorization.

F. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have the following rights regarding your health information. You may exercise each of these rights, in writing, by providing us with a completed form that you can obtain from the Surgery Center of Wasilla business office. In some instances, we may charge you for the cost(s) associated with providing you with the requested information. Additional information regarding how to exercise your rights, and the associated costs, can be obtained from **our business office**.

1. **Right to Inspect and Copy**. You have the right to inspect and receive copies of health information that may be used to make decisions about your care. We may deny your request to inspect and copy your health information in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.

2. **Right to Amend**. You have the right to request an amendment of your health information that is maintained by or for our clinic and is used to make health care decisions about you. We may deny your request if it is not submitted in writing or does not include a reason to support your request. We may also deny your request if the information sought to be amended: (a) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (b) is not part of the information that is kept by or for our clinic; (c) is not part of the information which you are permitted to inspect and copy; or (d) is accurate and complete.

3. **Right to an Accounting of Disclosures**. You have the right to request an accounting of the disclosures of your health information made by us. This accounting will not include disclosures of health information that we made for purposes of treatment, payment or health care operations or pursuant to a written authorization that you have signed.

4. **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone, such as a family member or friend, who is involved in your care or in the payment of your care. For example, you could ask that we not use or disclose information regarding a particular treatment that you received. We are not required to agree to your request. If we do agree, that agreement must be in writing and signed by you and us.

5. **Right to Request Confidential Communications**. . You have the right to request how we communicate with you to preserve your privacy. We may condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. You must submit your request in writing to our Privacy Officer. The request must specify how or where we are to contact you. We will accommodate all reasonable requests.

6. **Right to a Paper Copy of this Notice**. You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy or this Notice.

G. QUESTIONS OR COMPLAINTS.

You have the right to file a complaint with our Privacy Officer or with the Department of Health and Human Services if you believe we have violated your privacy rights, Complaints to the Privacy Officer must be in writing. We will not retaliate against you for filing a complaint.

FOR MORE INFORMATION:

If you have questions or would like additional information, you may contact our Privacy officer at 907-631-3578.

Surgery Center of Wasilla
3190 E Meridian Park Loop, Ste111
Wasilla, AK 99654

FOR OFFICE USE ONLY

SURGERY CENTER OF WASILLA made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

(Please list reasons below the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.)

Disclosure of Physician Ownership

We are pleased that you are scheduled at Surgery Center of Wasilla for your upcoming procedure. Your physician has chosen our facility because of his/her confidence in the ability of the surgery center to provide the quality of medical services you deserve. You should be aware, however, that your physician may have a financial interest in this facility. The following physicians have an ownership interest in Surgery Center of Wasilla.

- ***John T. Grissom, MD***
- ***Joseph Bell, MD***
- ***Wade Erickson, MD***
- ***Matthew Peterson, MD***
- ***Tak-Ming Ko, MD***
- ***Evan Wolf, MD PhD***
- ***Matt Heilala, DPM***
- ***Garth LeCheminant, MD***
- ***Andrew Pulliam, MD***
- ***John Oliver, MD***
- ***W. Vaughn Gardner, MD***
- ***Jeff Simerville, MD***
- ***Curtis Mina, MD***
- ***Adam Ellison, MD***

You are hereby advised that if you wish, you have the right to choose any other facility for the purpose of having your procedure performed. Not all facilities listed below may have medical services of the type you require, and/or physician may not have medical privileges at the facility of your choosing.

If you have questions concerning this disclosure please feel free to ask your physician. We welcome you as a patient and value our relationship with you.

Mat Su Regional Hospital
2500 S. Woodworth Loop
Palmer, AK 99645
907-861-6000

Alaska Regional Hospital
2801 DeBarr Road
Anchorage, AK 99508
907-861-6000

Surgery Center of Anchorage
4001 Laurel St., Suite A
Anchorage, AK 99508
907-563-1800

Providence Hospital
3200 Providence Drive
Anchorage, AK 99508
907-261-3049

PATIENT RIGHTS

SURGERY CENTER OF WASILLA, LLC is committed to providing comprehensive health care in a manner, which acknowledges the uniqueness and dignity of each patient. We encourage patients and families to have clear knowledge of, and to participate in, matters and decisions relating to their medical and surgical care.

Each patient receiving services in this facility shall have the following rights:

1. Understand and use these rights. If for any reason you do not understand or you need help, the SURGERY CENTER OF WASILLA, LLC must provide assistance, including an interpreter.
2. Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation or source of payment.
3. Receive consideration and respectful care in a clean and safe environment free of unnecessary restraints.
4. Be informed of the name and position of the doctor who will be in charge of your care at the Center.
5. Know the names, positions, and functions of any Center staff involved in your care and refuse their treatment, examination or observation.
6. Have your pain assessed and addressed in a timely manner.
7. Be informed if your surgeon has a financial interest in the Center.
8. Receive complete information about your diagnosis, treatment, and prognosis.
9. Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
10. Refuse treatment and be told what effect this may have on your health.
11. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
12. Privacy while at the Center and confidentiality of all information and records regarding your care.
13. Participate in all decisions about your treatment and discharge from the Center.
14. Review your medical record without charge. Obtain a copy of your medical record for which the Center can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
15. Receive an itemized bill and explanation of all charges.
16. Complain without fear of reprisal about the care and services you are receiving and to have the Center respond to you in writing if you request it. If you are not satisfied with the Center's response, you can complain to the:

1) **Department of Health** The State of Alaska: 907-334-2483 or http://www.hss.state.ak.us, toll free 1-888-387-9387, Fax 907-334-2682.

2) The office of the Medicare Beneficiary Ombudsman at 1-800-MEDICARE or go to: www.medicare.gov/ombudsman/activities.asp Select inquiries/complaint (Medicare recipients)

3) Accreditation Association for Ambulatory Healthcare, Inc. (AAAHC) at 847-853-6060 or http://www.aaahc.org/eweb

17. Know that the Center does not honor "Do Not Resuscitate" orders. If you have a DNR order you will be asked to suspend your DNR order while you are a patient at the Center.

SURGERY CENTER OF WASILLA

PATIENT RESPONSIBILITIES

Each patient receiving services in this facility shall have the following responsibilities:

1. It is the Patient's responsibility to read all permits and/or consents that he/she signs. If the patient does not understand, it is the patient's responsibility to ask the nurse or practitioner for clarification.

2. It is the Patient's responsibility to answer all medical questions truthfully to the best of his/her knowledge; providing complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies and sensitivities.

3. It is the Patient's responsibility to inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

4. It is the Patient's responsibility to read carefully and follow the preoperative instructions that his/her practitioner has given.

5. It is the Patient's responsibility to notify the organization if he/she has not followed the preoperative instructions.

6. It is the Patient's responsibility to provide transportation as directed to and from the organization appropriate to the medications and/or anesthetics that he/she will be receiving.

7. It is the Patient's responsibility to read carefully and to follow the postoperative instructions and treatment plan prescribed that he/she receives from the practitioner or nurses. This includes postoperative appointments.

8. It is the Patient's responsibility to contact his/her practitioner if he/she has any complications.

9. It is the Patient's responsibility to assure that all payments for services rendered are on a timely basis and that
ultimately, responsibility for all charges is his/hers, regardless of whatever insurance coverage he/she may
have.

10. It is the Patient's responsibility to be respectful of all the health care providers and staff, as well as other
patients.

11. It is the Patient's responsibility to notify the Medical Director if he/she feels that any of his/her Patient's
Rights have been violated or if he/she has a significant complaint or a suggestion to improve services or the
quality of care. This can be done by filling out our patient satisfaction questionnaire, by direct contact or by
telephone/fax/email.

Notice

Complaints may be lodged at the following locations:

SURGERY CENTER OF WASILLA, LLC
3190 E Meridian Park Loop, Ste 111
Wasilla, Alaska 99654
ATTN: Administrator
907-631-3578

MEDICARE PATIENTS MAY ALSO CONTACT:

The Office of the Medicare Beneficiary Ombudsman
http://www.medicare.gov/Ombudsman/activities.asp

Alaska State Department of Health
4501 Business Park Blvd., Ste 24, Bldg L
Anchorage, AK 99503
1-888-387-9378

AAAHC, Inc.
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
1-847-853-6060

SURGERY CENTER OF WASILLA

PATIENT CONCERNS AND/OR GRIEVANCES

It is the policy of the Surgery Center of Wasilla, LLC that all patients are provided a process by which they can present questions, concerns, and grievances about the Center. All patient concerns receive a timely and professional response.

Please contact the **Administrator** during regular business hours 907-631-3631 or write a statement and send it to:

Surgery Center of Wasilla, LLC, 3190 E Meridian Park Loop, Ste 111, Wasilla, Alaska 99654

If you are not satisfied with the resolution provided by the Center, you may contact:

1. Health Facilities Licensing and Certification, 4501 Business Park Blvd, Ste 24, Anchorage, Alaska 99503-7167. Toll Free: 1-888-387-9387. Fax: 907-344-2682;
2. Medicare Patients should visit the following website to understand your rights and protections: http:/www.cms.gov/center/ombudsman.asp
3. Accreditation Association for Ambulatory Healthcare, Inc (AAAHC) at 847-853-6060 or go to: www.aaahc.org

OUR SURGERY CENTER'S ADVANCE DIRECTIVE POLICY

An Advance Directive is a statement you make regarding the medical care you would like in a particular situation prior to actually needing the care. There are different types of Advanced Directives. The most common are living wills or durable power of attorney for healthcare. These documents allow you to communicate your care wishes to your care providers and others.

The majority of procedures performed at Surgery Center of Wasilla, LLC are considered to be of minimal risk. Of course, no surgery is without risk. You and your provider will have discussed the specifics of your procedure and the risk associated with your procedure, the expected recovery and the care after your surgery.

It is the policy of Surgery Center of Wasilla, LLC, 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 Surgery Center of Wasilla, LLC, 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 have an Advance Directive or Living Will, you may obtain more information, including instructions on how to complete one, at the State of Alaska's Division of Public Health website under Advance Health Care Directive:

http://www.hss.state.ak.us/dph/director/livingwill

You may also print a copy of Alaska's Advance Directive by calling Caring Connections at 1-800-658-8898.
For your convenience, Surgery Center of Wasilla also has copies available upon request.

SURGERY CENTER OF WASILLA

Dear Patient:

We are pleased that you have chosen Surgery Center of Wasilla for your upcoming procedure. In this packet you will find helpful information to help advise you of your rights and responsibilities, disclosure of physician interest, advance directive, and notice of privacy practices.

We are committed to providing you the quality medical services you deserve. Your comfort and care is our primary concern. Our customer service team is available to answer any questions or concerns you may have. Please note: Your driver will need to be within 10-15 minutes away from the center. It is important that they be able to pick you up in a timely manner.

Please do not hesitate to call us at (907)-631-3578.

Thank You,

The Medical Staff of Surgery Center of Wasilla