South Plains Surgery Center

Please print and fill out the attached Pre-Registration Forms, ***for pediatric patients***, and bring them with you on the day of your visit. If you have any questions or need assistance filling out these forms, please do not hesitate to contact me via email or phone.

Thank you,

The Staff of South Plains Surgery Center

South Plains Surgery Center
T: 806.451.5005
E: reception@southplainssc.com

SOUTH PLAINS
SURGERY CENTER

PATIENT INFORMATION

Patient Name (Last, First, Middle) | Social Security Number

Date of Birth | Age | Sex | Marital Status

Race: □American Indian □ Asian □Black/African American □Other Pacific Islander □Caucasian □Hispanic

Ethnicity: □Hispanic/ Latino □Non-Hispanic or Latino

Mailing Address **(City, State and Zip)** | Phone Number

Residing Address (If Different) | Cell Phone Number

Email Address

Employer

Employer's Address (City, State and Zip) | Employer's Phone Number

Guarantor/Responsible Party | Social Security Number | Relationship

Guarantor/Responsible Party's Mailing Address | Phone Number

Guarantor/Responsible Party's Employer

Guarantor/Responsible Party's Employers Address (City, State and Zip) | Employer's Phone Number

Person to Contact in an Emergency (Who Does Not Live with You)

Address (City, State and Zip) | Phone Number

INSURANCE INFORMATION

Primary Insurance Carrier | Policy Owner/s Name | Social Security Number | Date of Birth

Insurance ID Number | Group Number | Group Name

Mailing Address (City, State and Zip)

Secondary Insurance Carrier | Policy Owner's Name | Social Security Number | Date of Birth

Insurance ID Number | Group Number | Social Security Number | Date of Birth

Mailing Address (City, State and Zip)

IS THIS A WORK-RELATED INJURY? □YES □NO If "YES", Please Provide the Information Below.

Date of Injury | Date Reported to Employer | Supervisors Name

Employer | Employer Address | Telephone Number

***SPSC USE ONLY*: Date of Surgery_____ Physician _____Med Record #_____Date of Pre-Registration**

PATIENT INFORMATION

Employer's Workers Compensation Insurance Company File/Claim Number

ADMISSION AGREEMENT

Consent for Admissions: I request and consent to admission to South Plains Surgery Center (SPSC).

Consent to Medical 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 SPSC is under the direction of my attending physician(s) and that the Center is not responsible for acts of omission of my attending physician(s). There are certain types of operations and procedures, such as direct abortion, which are not authorized at the surgery center and I agree to such policy as condition of admission.

Release of Information: I authorize SPSC to release any medical or financial information to a medical care provider who is performing medical care or a diagnostic test(s) on behalf of; or at the request of my attending physician, or his/her designees, of the Center. I authorize SPSC, its agencies and designees, to utilize any information in my medical record for quality assurance and risk management activities. **By state law**, you must be advised that the information authorized for release may include records, which may indicate the presence of a communicable, or venereal disease, which includes, but is not limited to, disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Legal Guardian, Medical Durable Power of Attorney, Advance Directives:

Do you have a Legal Guardian? □ Yes □ No
If yes, please provide Name_____
Do you have a Medical Durable Power of Attorney? □ Yes □ No □ Copy on Chart
If yes, please provide Name_____
Do you have an Advance Directive? □ Yes □ No □ Copy on Chart

Privacy Practices, Patient Rights, Physician Ownership, Advance Directives and Patient Financial Responsibility Policies:

Have you received a copy of the SPSC Notice of Privacy Practices? □ Yes □ No
Have you received a copy of the SPSC Patient Rights and Responsibilities? □ Yes □ No
Have you received a copy of the SPSC Physician Ownership Statement? □ Yes □ No
Have you received a copy of the SPSC Advance Directives Policy? □ Yes □ No
Have you received a copy of the SPSC Patient Financial Responsibility Policy? □ Yes □ No

Personal Property: I have been informed and understand SPSC does not assume any responsibility for personal property that I choose to keep with me. I have been informed; however, that SPSC will keep my personal property in a designated location, upon request. I have been informed and understand that SPSC will not be liable for any loss of my personal property unless it is secured in a designated location maintained by SPSC.

Payment for Medical Care: I agree that, in consideration for the medical care I receive from the Center, its employees, agents, designees, or independent contractors, I guarantee full payment for all charges by SPSC or by other providers of medical care, for such care, subject only to restrictions imposed by the Medicare or State Medicaid Programs, or by any third party payor (for example, an insurance carrier or health maintenance organization (HMO) with which Center has specifically entered into an agreement for payment of medical care provided by the Center or by its employees, agents, designees or independent contractors.) In the event that SPSC has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented to and services provided herein, I agree to pay the reasonable attorney's fees and collection expenses, including, without limitation, collection agency expenses, incurred by SPSC.

Assignment of Benefits: I hereby authorize and assign payment to SPSC, any type of reimbursement or payment from Medicare or State Medicaid programs or other third-party payor, for any and all cost of my medical care provided at the Center or by its agents, designees, or independent medical contractors. Further, I understand that **Anesthesiology, Physician Services, Pathology, Radiology** and some **Laboratory Services** may be billed to me separately and I 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.

Insurance Precertification: I understand that precertification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.

Release of Financial Information: I hereby authorize SPSC, its employees, agents, designees, or independent contractor to disclose any and all information regarding the medical care I received on admission to this facility or through its employees, agents, and designees, or independent contractors to any third-party payor responsible for paying the costs of my medical care and any part thereof.

Agreement as to Governing Law and Forum: The patient or patient's representative and health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; (2) in the event of a dispute, any lawsuit, action or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

I have reviewed this Admission Agreement and fully understand its contents and implications.

_____

Signature of Patient, Parent, or Legal Guardian | Date | Please Print Name of Patient, Parent, Guardian

_____

Signature of Guarantor | Date | Please Print Name of Guarantor

_____

Employee Signature | Date | Please Print Name of SPSC Employee

If Legal Guardian or Other Representative for the Patient, please provide your age and relationship to the patient, and the reason why the Patient is incompetent or unable to sign. If an emancipated minor, please state whether you have lawfully married or are a parent or legal guardian of a child.

Permission for Disclosure to Family, Friends, and/or Caregivers

To Patient:

I understand patient health information is protected and confidential. With this understanding, I hereby grant the **South Plains Surgery Center** staff permission to discuss my health-related matters with family, friends, caregivers or other designated persons, listed below.

Relevant health information may be shared with the following family members, other relatives, close personal friends, or other persons identified. Please mark applicable line and insert name of person or persons applicable.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Disclosure UPDATED by patient:

Date and initial of patient: _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient Name: _____ **Date:** _____

Patient Signature: _____

PATIENT CONSENT TO RESUSCITATIVE MEASURES

Not A Revocation of Advance Directives or Medical Powers of Attorney

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers 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. This Center respects and upholds those rights.

However, unlike in an Acute Care Hospital setting, the 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 your surgery.

Therefore, regardless of the contents of any advanced directive or instructions from a healthcare surrogate or attorney, if an adverse event occurs during your treatment, we will initiate resuscitative or any other stabilizing measures & transfer you to an acute care setting for further evaluation. If you have an advanced directive, it is your responsibility to inform us of detailed information and provide a copy to our center on the day of the procedure.

If you do not agree to this policy, we are pleased to assist you to reschedule the 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, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY.

□ NO, I DO NOT HAVE AN ADVANCE DIRECTIVE. LIVING WILL OR HEALTH CARE POWER OF ATTORNEY.

□ I WOULD LIKE TO HAVE INFORMATION ON ADVANCE DIRECTIVES.

If you checked the first box "yes" to the question above, please provide us 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 contents and agree to the policy as described.

By: _____

Patient's Signature

Patient's Last Name:	Patient's First Name:	Date:

If consent to the procedure is provided by anyone other than the patient, this form must be signed by the person providing the consent or authorization.

I acknowledge that I have read and understand its contents and agree to the policy as described.

By: _____

Signature Print Name

Relationship to Patient:

□ Court Appointed Guardian □ Attorney in Fact □ Health Care Surrogate □ Other

PATIENT FINANCIAL RESPONSIBILITY

Recognizing the need for patients to understand what is expected regarding payment of medical services, we have established our financial policy. Some of these items are required by law. It is our goal to remain sensitive to our patients' needs while providing quality medical care. We encourage you to contact our office if a problem should arise regarding your account.

1. **All co-pays, deductibles, and co-insurances required by your insurance company must be paid at the time services are rendered.** We accept cash, checks, Visa, Mastercard, Discover, American Express, and Care Credit.

2. **It is the patient's responsibility to be aware of the contract benefits of his/her insurance carrier.** If your insurance requires referrals/pre-authorization for full benefits to be paid, it is your responsibility to verify that the referrals/pre-authorizations are in place prior to your visit.

3. **The facility charge at the surgery center is a flat fee for use.** All supplies are included in this charge except for billable prosthesis, implants, pharmaceuticals, or transplant tissue which are billed as separate charges.

4. **Our facility will file both primary and secondary insurance claims for medical services rendered.** Claims for a third insurance contract will not be filed unless required by our contract with the carrier. We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit.

5. **If you do not have insurance,** payment in full is expected at the time of service unless financial arrangements have been made in advance without billing department.

6. **You will receive a statement from our office within 45 days of your insurance company's response.** If you are dissatisfied with their payment, please contact your insurance carrier. Payment of the patient's portion of the balance is due upon receipt of the statement.

7. **We are participating providers for Medicare.** This means that we must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20% plus any out-of-pocket deductibles. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient by federal law, must be held responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

8. **Responsibility for payment for services rendered to the child/children of divorced or separated parents** rests with the parent who seeks treatment. Any court ordered judgement must be between the individuals involved, without including our facility.

9. **All accounts that are 60 days or more past due, may be turned over to a collection agency** and Lubbock Surgery Center may cease providing services to you.

10. **In the unlikely event, your payment is returned unpaid,** we may elect to re-present your payment either electronically (or by paper draft) to your financial institution up to two more times. We may also collect a return processing charge by the same means, in an amount not to exceed that permitted by state law.

It is our hope that you will find this information helpful. If you have any questions, please speak with our billing staff at (806) 412-6030 at 4412 6th Street, Lubbock, TX, 79416.

Medication Reconciliation Form

Source of Information:

□ Unable to Contact □ Patient Questionnaire □ Patient/Family _____ □ Pharmacy _____

□ **No Known Allergies**

Allergies

Allergy:	Reaction:	Allergy:	Reaction:	Allergy:	Reaction:

□ Allergies continued on attached

□ Medications continued on attached

Current Medication

□ **Patient is not currently taking any medications or supplements**

Medication	Dose	Frequency	Date of Last Dose	Resume Medication
				□today □other
				□today □other
				□today □other
				□today □other
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				□today □other

The current medication and allergy list are complete and accurate _____

Patient Signature

□**Patient has not been prescribed any new medications today**

_____ **Nurse Signature**

PRE ANESTHETIC ASSESSMENT- PEDIATRIC

Patient Name:_____

Responsible Party_____ Daytime Phone#_____Procedure_____

Wt_____(lbs)_____(kg) My nickname is_____ **NPO**: Time:_____ Verbalized Understanding

I am **allergic** to (**drug & food**)_____**Latex allergy /Sensitivity** to tape/band-aids**?** ☐ Yes ☐ No

Medications / Supplement(s) List: Med/Rec Form Completed **Yes** ☐ **No** Hospitalizations_____

Surgeries I have had _____Are immunizations up to date? ☐ Yes ☐ No

Anesthesia Problems: *Patient~*_____ *Relative~* _____

(i.,e. unexplained fever, MALIGNANT HYPERTHERMIA, nausea/vomiting)

I have pain ☐ **Yes** ☐ **No** Where? _____ If yes, is it Mild (0-3) Moderate (4-7) or Severe (8-10)

Patient lives with: _____ Last name if different: _____

Who will be with patient the day of surgery_____ ****Power of Attorney needed if child will be with someone other than custodial parent**** Other info the doctor should know: _____

PLEASE READ CAREFULLY AND CIRCLE ALL THAT APPLY TO YOUR CHILD

CARDIOVASCULAR	RESPIRATORY	NEUROMUSCULAR	AIRWAY
NO PROBLEM	**NO PROBLEM**	**NO PROBLEM**	**NO PROBLEM**
ANEMIA	ASTHMA	ADD / ADHD SPINAL DEFORMITIES	LOOSE TEETH:
BLEEDING TENDENCIES	ALLERGIES	CEREBRAL PALSY MUSCULAR DYSTROPHY	_____
MURMUR	NASAL CONGESTION	SEIZURE: FREQUENCY:_____	MISSING TEETH:
RHEUMATIC FEVER	RECENT COLD/INFECTIONS	MENTAL OR PHYSICAL DISABILITY OR DELAY	_____
OTHER:	OTHER:	***FAMILY HISTORY OF ABOVE*** ☐ YES ☐ NO	BRACES
		OTHER:	OTHER:

ENDOCRINE	GI / GU	BIRTH	MISCELLANEOUS
NO PROBLEM	**NO PROBLEM**	NORMAL FULL TERM	RASHES
DIABETES: CONTROLLED BY:	KIDNEY DISEASE	PREMATURE:	ANYTHING CONTAGIOUS
DIET MEDICATION INSULIN	URINARY INFECTION	Birth Wt._____	HEARING AIDS
RHEUMATOID ARTHRITIS	STOMACH PROBLEMS		GLASSES/CONTACTS
OTHER:	OTHER:	GROWTH/DEVELOPMENT FOR AGE:	Last Menstrual Cycle: _____
		Within normal limits YES ☐ NO	OTHER:

Please list the name(s) of your current physician(s) (i.,e. primary care physician, cardiologist, pediatrician):

Physician name	**Specialty**	**Date of visit**

Notes: _____

_____

_____

_____

_____

_____

_____

_____
Signature **Date**

 Parent ☐ Guardian Other

_____
Nurse Signature **Date**

I certify that my health history was reviewed and updated by me on:

Today's Date	**Patient/Parent/Guardian Signature**	**Witness**
Today's Date	**Patient/Parent/Guardian Signature**	**Witness**
Today's Date	**Patient/Parent/Guardian Signature**	**Witness**

CONSENT

- I voluntarily give my permission to the health care providers of South Plains Surgery Center and other health care assistants as deemed necessary to provide medical services to me. I understand that I should communicate any special considerations related to a cultural, spiritual, or ethical belief that may affect my plan of care.

- I ___(do) or ___ (do not) consent to the use of blood and blood products as deemed necessary. if declining; I understand that the refusal to receive blood products may be life threatening. The risks associated with receiving blood or blood products are: 1. Fever. 2. Transfusion reaction, which may include kidney failure or anemia. 3. Heart failure. 4. Hepatitis. 5. HIV (Human Immuno-Deficiency Virus) and/or AIDS (Acquired Immune Deficiency Syndrome) 6. Other infections.

- I authorize the pathologist at his discretion, to maintain or discard any bodily specimen.

- I understand that if I am discharged the same day as my surgery, I should not operate a motor vehicle or machinery, or potentially dangerous appliances, drink alcoholic beverages or make critical decisions for 24 hours, I understand that I must be accompanied by a responsible adult when I am discharged.

- I understand that my physician may order a blood test drawn from me for (including but not limited to) HIV (AIDS) and Hepatitis antibodies. I consent to that withdrawal only if an employee or physician has had an accidental exposure to my bodily fluids. I understand that I can obtain the results of these tests from my physician who can explain them. I authorize release of data necessary to process the testing and the insurance claim and I understand there will be no cost to me for this test.

- PHOTOGRAHS/VIDEO TAPES: I give my consent for any photographing or videotaping deemed necessary by my surgeon for medical, scientific or educational purposes provided my identity is not revealed. I understand these photographs and/or video tapes are the property of my surgeon.

- I understand that my name, address, telephone number and social security number could be provided to the manufacturer if part of my treatment includes implanting a medical device that falls under the tracking requirements of the Food & Drug Administration.

- I do not consent to the admittance of a:
  □ Resident assistant □ Resident observer □ Student observer □ Private Surgical Technician
  □ Private Registered Nurse □ Sales representative for the purpose of observation and consultation

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

DATE: _____ TIME: _____ A.M./P.M.

_____
Signature of Patient/Relative or Guardian*

Relationship if signed by person other than patient _____

_____
WITNESS/INTERPRETER:

South Plains Surgery Center

South Plains Surgery Center complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

PATIENT RIGHTS AND RESPONSIBILITIES
The facility and medical staff of South Plains Surgery Center have adopted the following list of patient rights and responsibilities. This list shall include, but not limited to:

PATIENT RIGHTS
The patient has the right:

- To exercise his or her rights without being subjected to discrimination or reprisal.
- To be free from all forms of abuse or harassment.
- To know of the name and professional status of those caring for him or her.
- To receive information from the physician about his or her diagnosis, treatment plan and prognosis to the best of the physician's knowledge.
- To participate actively in decisions regarding your medical care. To the extent permitted by law, this includes the right to refuse treatment.
- Of full consideration of privacy concerning your medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely.
- To receive responsible responses to any reasonable requests for service.
- To leave the facility even against medical advice.
- To expect reasonable continuity of care.
- To be advised if the physician proposes to engage or perform experimentation affecting your care of treatment and the right to refuse to participate in the activity.
- To be informed of the continuing health care requirements following discharge from the center.
- To examine and receive an explanation of a bill or service, regardless of source of payment.
- To report any comments concerning the quality of care provided to you and expect follow-up on your comments.
- To be informed of their right to change providers if other qualified providers are available.

PATIENT RESPONSIBILITIES
The Patient is responsible:

- For providing accurate and complete information concerning his present complaints, past medical history and other matters relating to their health.
- For making it known whether they clearly comprehend the course of their treatment and what is expected of them.
- For following the treatment plan established by the physician, including the instructions of nurses and other health care professionals as they carry out the physician's orders.
- For keeping their appointment and notifying the facility if they are unable to do so.
- For providing a responsible adult to drive them home and stay with them for 24 hours after surgery.
- For providing complete and accurate insurance information (if applicable) and assuring that the financial obligations of their care are fulfilled as promptly as possible.
- For being considerate of the rights of other patients and facility personnel.

ADVANCED DIRECTIVE
The Center is not an acute care facility; therefore, regardless of the contents of any advanced directive or instructions from a healthcare surrogate or attorney, if an adverse event occurs during your treatment, we will initiate resuscitative or any other stabilizing measures & transfer you to an acute care setting for further evaluation. If you have an advanced directive, it is your responsibility to inform us of detailed information and provide a copy to our center on the day of the procedure.

FEEDBACK
Our goal is to provide the best surgical experience possible while in our center. Patients, clients, families or visitors have the right to express complaints or concerns about any aspect of their care or experience with South Plains Surgery Center. Please be assured that expressing a complaint or concern will not compromise your care.

Concerns may be directed to any SPSC staff member, the Director of Nurses or the Director of Business Services.

You may also mail your comments to:
South Plains Surgery Center Administrator
4412 6th Street
Lubbock, TX 79416

If this venue does not provide you with an acceptable resolution, any complaints may be submitted to:
Health Facility Compliance Division/MC 1979
Texas Department of Health
1100 West 4th Street, Austin, TX 78756
Fax: (512) 834-6653 Telephone: (888)973-0022

For more information, please visit the Office of the Medicare Beneficiary Ombudsman via the internet at: www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html or by calling 1(800)MEDICARE.

NON-DISCRIMINATION NOTICE

DISCRIMINATION IS AGAINST THE LAW

South Plains Surgery Center, LLC (SPSC) complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, age disability or sex. SPSC does not exclude people or treat them differently because of race, color, national origin, age disability, or sexual orientation.

SPSC provides free aid and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and some written information in other formats upon request (large print, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as: qualified interpreters, information written in other languages.

If you need these services you may contact Margarita Castro RN, Clinical Director. If you believe that the Surgery Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age disability or sexual orientation you can file a grievance with: Michelle Sahinler MD, Administrator, at 4412 6th Street, Lubbock, Texas 79416 or (806) 451-5005, michelle@southplainssc.com. You can file a grievance in person or by mail or phone. If you need help filing a grievance, Michelle Sahinler MD is available to assist you.

You can also file a civil complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.isf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, (800) 537-7697 (TDD). Complaint forms are available at https//www.hhs/gov/ocr/office/file/index/html.

South Plains Surgery Center, LLC (SPSC) cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. LSC no excluye a las personas ni las tratas de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

SPSC proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes: intérpretes de lenguaje de señas capacitados. Información escrita en otros formatos (letra grande, formatos electrónicos accesible, otros formatos). Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes: Interpretes capacitados. Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con Margarita Castro RN, Clinical Director. Si considera que the Surgery Center no le proporciono estos servicios o lo discrimino de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: Michelle Sahinler MD, Administrator, at 4412 6th Street, Lubbock, Texas, 79416 or (806) 451-5005, michelle@southplainssc.com. Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, Michelle Sahinler MD está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office For Civil Rights (oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. De manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs/gov/ocr/portal/lobby.isf, o bien, por correo postal a la siguiente dirección o por teléfono a los numeros que figuran a continuacion: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C., 20201, (800) 537-7697 (TDD). Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.

SOUTH PLAINS SURGERY CENTER

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Officer at 4412 6TH Street, Lubbock, TX 79416 or (806)451-5005.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health Information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways we may use and disclose health information that identities you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by contacting our Privacy Officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party, for the treatment and services you received. For example, we may give your health plan Health Information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operations purposes, including outside of Lubbock Surgery Center. For example, we may use and disclose Health Information to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities. We may also share your information for the training of medical residents, students or trainings for their training and educational purposes as they participate in educational programs, training, internships and residency programs.

Appointment Reminders, Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Family and Friends Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may use and disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract with them.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may use and disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths, report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using, a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition, and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use an disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain ve limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determin the cause of death. We also may release Health Information to funeral directs, as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Protective Services for the President and Others. W may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional

institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care: (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information, as necessary, if we determine that it is in your best interest based on our professional judgement.

Disaster Relief. We may disclose your Health Information to disaster relief organizations that see your Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Health Information will be made only with your written authorization:

1. Uses and disclosures of Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Health Information

Other uses and disclosures of Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Health Information under the authorization. However, disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Review and Copy: You have a right to review and request copies of your Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Privacy Officer. We may charge you a reasonable fee to copy and/or mail the requested Health Information as permitted by law. If we are able we will provide an electronic copy to you within 15 days of your written request and receipt of appropriate fee.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Health Information, as required under state and federal law.

Right to Amend. If you feel that the Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we have made of Health Information for purposes other than treatment, payment and health care operations for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Privacy Officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we will not bill your health plan) in full for a specific item or service, you have the right to ask that your Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to 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 of this notice. You may obtain a copy of this notice at our web site, www.southplainssc.com. To obtain a paper copy of this notice contact the Privacy Officer.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make this notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer. All complaints must be made in writing. **Your care will not be affected in any way for filing a complaint.**

Notice of Privacy Practices

Effective Date: **August 1, 2018**

PHYSICIAN OWNERSHIP STATEMENT

The physician and entity listed below are limited partners in South Plains Surgery Center, L.L.C. An interest in this facility enables them to have a voice in the administration and medical policies of this heath care institution. This involvement helps ensure the finest quality of care for their patients. South Plains Surgery Center, L.L.C. places special emphasis on fully informing our patients of this ownership. It is our goal to inform you and treat you professionally at all times.

Elias Ghandour, M.D.

Juan Kurdi, M.D.

James T. Rose, M.D.

Matthew Soape, M.D.

Ruben Villa, M.D.