

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # _____

Work # _____

Mobile # _____

Other _____

Place Patient Identification Label Here

E-Mail Communication Preferences

Email Address _____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Scripps Encinitas Surgery Center or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, Scripps Encinitas Surgery Center or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update Scripps Encinitas Surgery Center when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

Patient's Signature for consent to text message.

Mail Communication Preferences

May we send mail to your home address? (If no, please provide an alternate mailing address below.)

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	<u>Name:</u>	<u>Telephone</u>
<input type="checkbox"/>	Spouse _____	_____
<input type="checkbox"/>	Caretaker _____	_____
<input type="checkbox"/>	Child _____	_____
<input type="checkbox"/>	Parent _____	_____
<input type="checkbox"/>	Other _____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

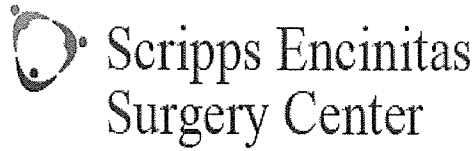
I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

Patient or Personal Representative Signature

Date

Printed Name

Relationship to Patient



The California Health & Safety Code (Section 128737) requires that medical facilities collect and submit required information to the Office of Statewide Health Planning & Development beginning January 1, 2005. We have all of the required information except for the information requested below. This information will be used by the State of California in the development and improvement of healthcare services and products.

Patient Label

Race:

- American Indian (R1)
- Asian (R2)
- Black/African American (R3)
- Native Hawaiian/Pacific Islander (R4)
- Caucasian (R5)
- Other Race (R6)
- Unknown (99)

Ethnicity:

- Hispanic/Latino (E1)
- Non-Hispanic/Non-Latino (E2)
- Unknown (99)

7. PRIMARY LANGUAGE SPOKEN: (Check one)

- ARABIC ARMENIAN CAMBODIAN CHINESE ENGLISH FRENCH GERMAN
- GREEK HINDI HUNGARIAN ITALIAN JAPANESE KOREAN POLISH PORTUGUESE
- RUSSIAN SPANISH VIETNAMESE UNKNOWN

8. IF THIS IS AN ACCIDENT OR INJURY PLEASE ANSWER THESE QUESTIONS:

1ST date of injury or illness: _____

Work Related: Y N

Claim# _____ DOI: _____

Auto Related: Y N

Place of Accident: _____

Another Party Resp: Y N

Other: _____

Brief Description of how injury or accident occurred:

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

Name of Patient

Signature of Patient

_____/_____/_____
Date Signed

Name Patient's Personal Representative

Signature of Patient's Personal Representative

_____/_____/_____
Date Signed

FOR INTERNAL USE ONLY

Name of Employee

Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

- Patient was unable to sign.
- Patient refused to sign.
- Other _____

____ - ____ (Version: As noted on NPP)

____/____/____ (Date: As noted on NPP)

**NOTICE OF PRIVACY
PRACTICES (NPP)
ACKNOWLEDGEMENT**

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PATIENT COMPLAINT OR GRIEVANCE

To report a complaint or grievance you can contact the facility Administrator by phone at (760) 632-3900 or by mail at:

Scripps Encinitas Surgery Center
320 Santa Fe Drive, LL 2
Encinitas, CA 92024

Complaints and grievances may also be filed through the State of California Department of Public Health at:

California Department of Public Health
Licensing and Certification Program
San Diego North District Office
Phone: (619) 278-3700
(619) 278-3725
www.dhs.gov/lnc

OR

JCAHO
Office of Quality Monitoring
1-800-994-6610
complaint@jointcommission.org

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman’s webpage on the web at: www.cms.hhs.gov/center/ombudsman.asp

OUR SURGERY CENTER’S ADVANCE DIRECTIVE POLICY

An ‘Advance Directive’ is a general term that refers to your oral and written instructions about your future medical care, in the event that you become unable to speak for yourself. In the State of California, 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 prior expressed wishes, when the patient is unable to make decisions or unable to communicate decisions. Scripps Encinitas Surgery Center respects and upholds those rights.

However, unlike in an acute care hospital setting, Scripps Encinitas Surgery Center does not routinely perform “high risk” procedures. While no surgery is without risk, most procedures performed in this facility are considered to be of minimal risk and are elective. 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, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during the your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation.

At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or health care Power of Attorney. Your agreement with this facility’s policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you wish to complete an Advance Directive, copies of the official State forms are available at your physician’s office or at: http://www.calhealth.org/Download/AdvanceDirective_English.pdf or, http://www.calhealth.org/Download/AdvanceDirective_Spanish.pdf

If you do not agree with this facility’s policy, we will be happy to assist you in rescheduling your procedure at an acute hospital.

DISCLOSURE OF OWNERSHIP

Scripps Encinitas Surgery Center is proud to have a number of quality physicians invested in our facility. Their investment enables them to have a voice in the administration of policies at our facility. This involvement helps to ensure the highest quality of surgical care for our patients. Your physician may or may not have an ownership interest in this facility, as not all physicians who practice here do have an ownership interest.

By signing this document, I acknowledge that I have read and understand its contents:	
Patient/ Patient Representative	Date
Witness	Date

PATIENT RIGHTS

- Receive access to equal medical treatment and accommodations regardless of race, creed, sex, national origin, religion or sources of payment for care.
- Be fully informed and have complete information, to the extent known by the physician, regarding diagnosis, treatment, procedure and prognosis, as well as the risks and side effects associated with treatment and procedure prior to the procedure.
- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice grievances regarding treatment or care that is (or fails to be) furnished.
- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.
- Receive the care necessary to regain or maintain his or her maximum state of health and if necessary, cope with death.
- Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience, as well as perform the services for which they are responsible with the highest quality of services.
- Be fully informed of the scope of services available at the facility, provisions for after-hours care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.
- Make informed decisions regarding his or her care.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, or as required by law or third party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care of treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time.
- Access to and/or copies of his/her medical records.

- Be informed as to the facility's policy regarding advance directives/living wills.
- Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the patient transfer.
- Express those spiritual beliefs and cultural practices that do not harm or interfere with the planned course of medical therapy for the patient.
- Expect the facility to agree to comply with Federal Civil Rights Laws that assure it will provide interpretation for individuals who are not proficient in English.
- Have an assessment and regular assessment of pain.
- Education of patients and families, when appropriate, regarding their roles in managing pain.
- To change providers if other qualified providers are available.

If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.

If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state laws may exercise the patient's rights to the extent allowed by state law.

PATIENT RESPONSIBILITIES

- Be considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the facility.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.
- Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.
- Providing care givers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
- Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting to care at the facility.
- Promptly fulfilling his or her financial obligations to the facility.
- Identifying any patient safety concerns.