

Medical Arts Surgery Center believes it is important for you to take an active part in your health care. That is why we have provided you with the list below. By becoming familiar with these points, you can better participate in your care and act as a vital part of the health care team. If you have any questions or concerns about your rights and responsibilities or this Notice, please ask to speak with the Manager or Assistant Nurse Manager, or call them at 786-662-5512.

NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES, ADVANCE DIRECTIVES AND PHYSICIAN OWNERSHIP DISCLOSURE

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care, and that you respect the health care provider's or health care facility's right to expect a certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities are as follows:

RIGHTS: A patient has the right to:

- ♦ Be treated with courtesy and respect, with appreciation of his/her individual dignity and with protection of his/her need for privacy
- ♦ A prompt and reasonable response to questions and requests
- ♦ Know who is providing medical services and who is responsible for his/her care
- ♦ Know what patient support services are available if he/she does not speak English
- ♦ Know what rules and regulations apply to his/her conduct
- ♦ Be given, by his/her health care provider/facility, information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis
- ♦ Refuse treatment, except where otherwise provided by law
- ♦ Be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care
- ♦ Know, in patients eligible for Medicare, upon request and in advance of treatment, whether the health care provider/facility accepts the Medicare assignment rate
- ♦ Receive, upon request and prior to treatment, a reasonable estimate of charges for the medical care
- ♦ Receive a copy of a reasonably clear and understandable itemized bill, and, upon request, to have charges explained
- ♦ Impartial access to medical treatment and accommodations regardless of race, national origin, religion, physical disability, or source of payment
- ♦ Treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- ♦ Appropriate assessment and management of pain, and, the right to a quick response to reports of pain
- ♦ Know if medical treatment is for the purpose of experimental research, and to give his/her consent or refusal to participate in such experimental research
- ♦ Express grievances regarding any violation of his/her rights, as stated in Florida law, through the grievance procedure of the health care provider/facility which served him/her, and to the appropriate state licensing agency
- ♦ Receive care in a safe setting
- ♦ Be free from all forms of abuse or harassment
- ♦ **An Advance Directive**, including a living will or a health care proxy. These documents express your choices about your future care or name someone to decide your care if you cannot speak for yourself. Because we provide surgery and procedures that are considered to be elective, our policy states that we do not honor Advance Directives and we will initiate resuscitative or other stabilizing measures and transfer you to an acute-care hospital for further evaluation. At the acute-care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Healthcare Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current Healthcare Directive or Healthcare Power of Attorney.
 - If you have a written Advance Directive, you should provide a copy to the Medical Arts Surgery Center at South Miami, your family, and your doctor.
 - If you do not have a form and desire one, we will assist you in obtaining one.
 - If you do not agree with this facility's policies on Advance Directives, we will be pleased to help you reschedule your procedure.

RESPONSIBILITIES: A patient is responsible for:

- ♦ Providing the health care provider/facility, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health
- ♦ Reporting unexpected changes in his/her condition to the health care provider/facility
- ♦ Reporting to the health care provider/facility whether he/she comprehends the contemplated course of treatment and what is expected of him/her
- ♦ Following the treatment plan recommended by the health care provider
- ♦ Keeping appointments, and when he/she is unable to do so for any reason, notifying the provider/facility
- ♦ His/her actions, if he/she refuses treatment or does not follow the health care provider's/facility's instructions
- ♦ Assuring that the financial obligations of his/her health care are fulfilled as promptly as possible
- ♦ Following health care and facility rules and regulations affecting patient care and conduct

FILING COMPLAINTS:

If you have a complaint against an ambulatory surgery center, call the **Consumer Assistance Unit at 1-888-419-3456 (Press 1)**, or write to:

**AGENCY FOR HEALTH CARE ADMINISTRATION, Bureau of Health Facility Regulation
2727 Mahan Drive, Mail Stop #31, Tallahassee, Florida 32308**

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

**AGENCY FOR HEALTH CARE ADMINISTRATION, Consumer Services Unit
4052 Bald Cypress Way, Bin C-75, Tallahassee, FL 32399-3275**

In addition to filing complaints with the Agency for Health Care Administration set forth in this Notice of Patient Rights and Responsibilities document, you can visit the Centers for Medicare and Medicaid's Office of the Medicare Ombudsman's:

<http://www.medicare.gov/Ombudsman/activities.asp>

PHYSICIAN OWNERSHIP DISCLOSURE:

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

Please be advised that you have the right to obtain the health care items and services for which you have been referred at any location or from any ambulatory surgery center, hospital, provider or supplier of your choice, including the Medical Arts Surgery Center at South Miami.

I received a copy of this Notice in advance of my date of procedure. I have read and understand this document.

Print Name

Patient/Guardian Signature

Date Received

PLEASE SIGN AND DATE THIS FORM WHEN RECEIVED AND BRING IT WITH YOU ON THE DAY OF SURGERY.