Mandatory Information Given to Patient
Date_____ Initial_____
Date of last office H & P_____
Patient Bill of Rights / **Patient Brochure**
Physician Ownership Disclosure or / **NA**

Southwestern Ambulatory Surgery Center
500 Lewis Run Road – Suite 202
Pittsburgh PA 15122
Phone 412-469-6964 Fax 412-469-6948

Surgeon:_____Referring Physician:_____ **SEE ATTACHED H & P**

Date of Surgery:_____Requested_Start Time:_____ Est. Time for Procedure_____ Date of Birth_____

Patient Name:_____SSN#_____ Circle: M / F
Last First Middle

Address:_____
Street City/State Zip Code

Home#_____
Work/Cell#_____
Ok to speak to:_____
Name

If Child, parent's or legal guardian's name:_____

Patient Concerns (circle): Latex Allergy Diabetes Pacemaker AICD Sleep Apnea Transplant History
Lack of Family Support MRSA Other:_____

Does Patient Use: Wheelchair Walker Crutches Cane Prosthesis Is Patient a Fall Risk (circle): YES NO

Procedure Information – IMCOMPLETE FORMS WILL BE RETURNED
PLEASE WRITE LEGIBLY IN ORDER TO AVOID ANY WRONG SITE SURGERIES ** DO NOT USE ABBREVIATIONS

PRIMARY CPT CODE_____**ICD 10 DX CODE**_____

DESCRIPTION PRIMARY PROCEDURE:_____

SECONDARY CPT CODE_____**ICD 10 DX CODE**_____

DESCRIPTION SECONDARY PROCEDURE:_____

Document Exact site, level, digit:_____CIRCLE ONE: RIGHT LEFT

Name of Implants (if applicable):_____

Anesthesia: GA MAC LOCAL SPINAL REG BLOCK BIER BLOCK

Patient Height_____ Patient Weight_____ BMI_____

Rep Name_____
Contact#:_____

C-Arm Needed: Yes No Sales Rep Needed : Yes No Rep Notified: Yes No
Special Equipment Needs:_____
Pre-Test Ordered: No Yes - If yes, please circle: CBC/Lytes EKG Chest X-Ray UA PCP Clearance Other_____
Comments:_____

Insurance Information
Primary Insurance:_____ Policy #:_____ Group #_____ Subscriber Name:_____DOB:_____
Insurance Phone #_____ Date of Accident_____
Verified:_____ Name of Rep:_____ Date:_____
Pre-Auth#:_____ Comments:_____
Billing Address:_____

Secondary Insurance:_____Policy #:_____ Group #_____
Subscriber Name:_____DOB:_____
Insurance Phone #_____

Responsible Party Information (If other than Patient)
Name:_____ DOB:_____ SS#_____
Last First Middle
Address:_____
Street City/State Zip Code Relationship

SWASC SCHEDULING RESERVATION FORM

Word/SWASC/forms/scheduling request form-ltan

SOUTHWESTERN AMBULATORY SURGERY CENTER

500 Lewis Run Rd. Suite 202
Pittsburgh, PA 15122
Tel. (412) 469-6964
Fax (412) 469-6948

ID: Acct:
DOB: AGE: SEX:
DOS:

CONSENT TO MEDICAL AND SURGICAL PROCEDURES

I,_____, hereby consent to the medical/surgical procedures outlined below, to be performed by **Dr. Courtney Uselton** assistant and appropriate facility personal. I understand that the aforesaid doctors(s)/dentist(s) are not employees or agents of Southwestern Ambulatory Surgery Center and represent that Southwestern Ambulatory Surgery Center and its employees have made no recommendations that have influenced my selection of said doctor(s)/dentist(s). I consent that other associates of my doctor/dentist may assist in my procedure in the event of an emergency or complications.

The medical/surgical procedure proposed is for **fillings, crowns, pulp therapy, sealants and/or extraction** diagnosis/treatment of **Dental Caries and/or Abscessed Teeth**. This procedure has been explained in terms understandable to me, which explanation has included:

(1)the nature and extent of the procedure to be performed;
(2)risks involved, including those which, even though unlikely to occur, involve serious consequences;
(3)alternative procedures and methods of treatment; advantages and benefits of SWASC as a site of surgery;
(4)the dangers and probable consequences of such alternatives (including no procedure or Treatment);
(5)the estimated period of hospitalization and/or incapacity and the estimated period of convalescence (assuming there are no complications);
(6)the expected consequences of the procedure upon my future health.

I understand that there are other risks, such as infection and other serious complications, in the pre-operative and post-operative stages of my care, which can result in serious consequences such as the loss of the use of parts of my body and life. I also authorize the Surgery Center to dispose of any severed tissue, organs or body parts in accordance with its policies.

I have asked all of the questions which I thought were important in deciding whether or not to undergo treatment or diagnosis. Those questions have been answered to my satisfaction. I understand that no assurance can be given that the procedure will be successful, and no guarantee or warranty of success or cure has been given to me. I have been afforded the opportunity to consult with other doctors/dentist, to my complete satisfaction before signing this form, and I understand that I have the right to refuse any medical and surgical procedures and treatment.

I further authorize and request my doctor/dentist, assistants and appropriate facility personnel to perform such additional procedures which in their judgment are incidentally necessary or appropriate to carry out my diagnosis/treatment.

I understand that my blood may be drawn and tested for Hepatitis and HIV antigens and/or antibodies in the event of a significant exposure of a health care worker to my blood or bodily fluids during the course of the medical/surgical procedure. If this testing becomes necessary, the policies and procedures regarding this exposure will be implemented as listed in the Surgery Center Exposure Control Plan.

I am aware that my physician may have a financial and ownership interest in Southwestern Surgery Center. I acknowledge that I have selected Southwestern Surgery Center at which to have the procedure performed after considering both my physicians financial interest in SWASC and my ability to have the procedure performed at a different facility or in a hospital.

I certify that I have read and fully understand the above consent statement, that the explanations therein referred to were made by **Dr. Courtney Uselton**and are understood by me, that all blanks or statements requiring insertion or completion were filled in prior to the time of my signature, and that this consent is given freely, voluntarily, and without reservation.

_____ _____ _____ _____
(Witness to Signature) (Patient or Person Signing on behalf patient) (Relationship to Patient) (Date/Time)

Consent verified with patient if obtained over 30 days _____RN Date/Time_____

Physician Signature_____

CONSENT TO MEDICAL AND SURGICAL PROCEDURES

SOUTHWESTERN
AMBULATORY
SURGERY CENTER

500 Lewis Run Rd, Suite 202
Pittsburgh, PA 15122
Tel. (412) 469-6964
Fax (412) 469-6948

ID: Acct:
DOB: AGE: SEX:
DOS:

Patient's Communication Preferences Regarding their Protected Health Information (PHI) & Advance Directives Acknowledgement

Telephone Communication Preferences

Home # _____ Work # _____ Mobile # _____ Other# _____

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 Southwestern Ambulatory Surgery Center or one of its legal agents or affiliates 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 Southwestern Ambulatory Surgery Center, its legal agents or affiliates 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 Southwestern 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)

- ☐ **Spouse** _____ **Phone**_____
- ☐ **Caregiver**_____ **Phone**_____
- ☐ **Other** _____ **Phone**_____
- ☐ **Child** _____ **Phone**_____
- ☐ **Parent**_____ **Phone**_____

I understand that there are several types of **advance directives**, the two most common forms are living wills and durable power of attorney designation. I understand that in the ambulatory care setting, if I suffer a cardiac or respirator arrest or other life threatening situation, signing this document grants consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with Federal Law, the facility is notifying you that it will only honor previously signed advanced directives after discussion with your physician and anesthesia provider to document any life-saving measures that are to be excluded.

Please check the following:

_____ I have _____ I have not signed a living will – Copy provided to SWASC NO YES

_____ I have _____ I have not signed a durable healthcare power of attorney – Copy provided to SWASC NO YES

I have been informed that it is the written policy of Southwestern Ambulatory Surgery Center to implement CPR and other forms of advanced life support measures in the event of a cardiac and/or respiratory arrest which occurs while I am under their care. Any exceptions are documented below and have been discussed with my doctor as my expressed wishes:

Circle: No Exceptions or Exceptions (add details):

Please list exceptions to Southwestern's Advance Directive Policy:_____

_____

(Doctor and Anesthesia Provider Signature necessary for exceptions ONLY)

Surgeon Signature:_____ Anesthesia Provider Signature:_____

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.
I acknowledge that I have been given the opportunity to request additional information on advance directives and living wills.

Patient Signature or Responsible Adult Signature:_____ **Date:**_____

Southwestern Ambulatory Surgery Center Witness:_____ **Date:**_____

Southwestern Ambulatory Surgery Center

PEDIATRICIAN DENTAL NOTIFICATION FORM

Dear Dr._____
PRIMARY CARE PHYSICIAN

Please be advised of the following information regarding one of your patients:

Dr. _____ has scheduled your patient,

_____ for the following procedure:
PATIENT NAME PATIENT DOB

_____ on _____ at
DATE OF SURGERY

Southwestern Ambulatory Surgery Center, under (circle anesthesia type):

GENERAL MONITORED ANESTHESIA CARE REGIONAL BLOCK LOCAL ANESTHESIA

Per the Pennsylvania Department of Health Rules and Regulations for the Ambulatory Surgery Facilities (Chapter 551), documentation in the medical records is required that you be notified of the use of an Ambulatory Surgery Center for the proposed procedure on this patient, who is under 18 years of age.

To your knowledge does this child have any health problems that you are aware of that would preclude him/her from having General Anesthesia with an endotracheal tube for their dental procedure to be done in a free standing surgery center. **YES / NO (if NO contraindications – please sign and fax to 412-469-6948)**

Signature:_____

If there are any additional medical problems, comments, or questions regarding this child's procedure or the patient's medical condition please call or send that information to us at the numbers listed below.

Please fax this form and any additional information to the surgery center 412-469-6948.

Southwestern Ambulatory Surgery Center
500 Lewis Run Road, Suite 202
W. Mifflin, PA 15122
(412) 469-6964 FAX (412) 469-6948

or

Surgeon address_____
Phone:_____
Fax:_____

Thank you for the opportunity to assist in the care of this patient.

FOR OFFICE USE ONLY – FORM SENT TO PCP BY:_____ DATE PCP

FAX TO:_____ DATE FAXED:_____ RET FORM_____

MAILED:_____ DATE MAILED:_____ * DID NOT RET FORM_____

*If form was not returned by PCP, PCP office was contacted and/or message left by SWASC or office staff:
Date_____ Staff Initals_____ PCP Office Returned Call: YES_____ NO_____
(date)

To Southwestern Ambulatory Surgery Staff Doctors:
Please return a completed copy to SWASC prior to expected date of surgery. Please attach Fax verification.
WORD/SWASC/FORMS:Pedcare

Patient Registration Guide

Physician: _____ Procedure Date: _____

Southwestern Ambulatory Surgery Center asks that you complete online registration with One Medical Passport. The website will guide you to enter your medical history so that we may provide you with excellent care and minimize long phone interviews and paperwork.

Begin Registration on Our Website

Start on our home page www.southwesternasc.com and click "Online Clinical History" to go to One Medical Passport (shown below).

Create Your One Medical Passport Account

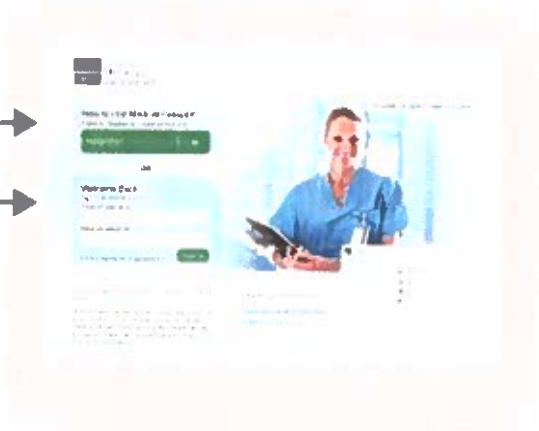
First time users of One Medical Passport should click the green **Register** button and create an account. Answer the questions on each page, then click save and continue. Once complete, you will be prompted to click **Finish** to securely submit your information to us.

First Time Users Click Register

Username you chose: _____

Returning Users (for changes or reuse)

Enter the username and password you chose. You can then access or update your account.



Additional Help to Complete Registration

Each page has a **Help** link you may click for assistance. If you are not able to complete your history online, please call our pre-op nurse during business hours at 412-469-6964 to complete your history over the phone.

ONE MEDICAL PASSPORT

a new direction in health care

Southwestern Ambulatory Surgery Center

Help Keep Our Patient's, Staff & Visitors Safe

The pandemic of 2020 certainly has changed the ways we help safe-guard our patients and staff at Southwestern.

We are following CDC guidelines and recommendations in order to accomplish these safety goals. Temperatures are being taken daily for staff, patients and visitors upon entrance to the facility. Masks must be worn at all times. No patient, physician or visitor will be permitted in any areas of the center without a mask.

During the pre-operative phone call, the patient will be screened for any possible infection or exposure and will be asked to self-isolate at the minimum of one week prior to surgery and to take temperature daily. To practice social distancing, we are instructing our patients to arrive solo to the surgery center and have their family members either remain in their car or in the lobby to avoid close contact with others. Should the patient be a minor, one parent/guardian is permitted to be with the minor. Also, should a patient with physical disability require assistance to the surgery center, they will be permitted to come with the patient to assist.

Our infection control procedures are in place and our staff has been trained in the required practices. We are committed to keep our patients and staff as safe as possible by frequent hand washing, cleaning high touched areas regularly, wearing masks and practicing social distancing through the facility.

Please call us at 412-469-6964 if you would have any questions or need additional information related to our COVID protocols or infection control policies.

Forms/patient and visitor

500 N Lewis Run Road, Suite 202 • Pittsburgh, PA 15122 • 412 / 469-6964 • FAX 412 / 469-6948

United Surgical Partners
INTERNATIONAL

NOTICE OF PRIVACY PRACTICES

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

Who Presents this Notice

The references to "Facility" and "Health Professionals" in this notice refer to the members of the United Surgical Partners International Affiliated Covered Entity. An Affiliated Covered Entity (ACE) is a group of organizations under common ownership or control who designate themselves as a single Affiliated Covered Entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The Facility, its employees, workforce members and members of the ACE who are involved in providing and coordinating health care are all bound to follow the terms of this Notice of Privacy Practices ("Notice"). The members of the ACE will share PHI with each other for the treatment, payment and health care operations of the ACE and as permitted by HIPAA and this Notice. For a complete list of the members of the ACE, please contact the Privacy & Security Compliance Office.

Privacy Obligations

Each Facility is required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. The Facility uses computerized systems that may subject your Protected Health Information to electronic disclosure for purposes of treatment, payment and/or health care operations as described below. When the Facility uses or discloses your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

Notifications

The Facility is required by law to protect the privacy of your medical information, distribute this Notice of Privacy Practices to you, and follow the terms of this Notice. The Facility is also required to notify you if there is a breach or impermissible access, use or disclosure of your medical information.

Permissible Uses and Disclosures Without Your Written Authorization

In certain situations your written authorization must be obtained in order to use and/or disclose your PHI. However, the Facility and Health Professionals do not need any type of authorization from you for the following uses and disclosures:

Uses and Disclosures for Treatment, Payment and Health Care Operations. Your PHI may be used and disclosed to treat you, obtain payment for services provided to you and conduct "health care operations" as detailed below:

Treatment. Your PHI may be used and disclosed to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, you may be contacted to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be

of interest to you. Your PHI may also be disclosed to other providers involved in your treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because if you do, this may impact your recovery.

Payment. Your PHI may be used and disclosed to obtain payment for services provided to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("Your Payor") to verify that Your Payor will pay for health care. The physician who reads your x-ray may need to bill you or your Payor for reading of your x-ray therefore your billing information may be shared with the physician who read your x-ray.

Health Care Operations. Your PHI may be used and disclosed for health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you. For example, PHI may be used to evaluate the quality and competence of physicians, nurses and other health care workers. PHI may be disclosed to the Privacy & Security Compliance Office in order to resolve any complaints you may have and ensure that you have a comfortable visit. Your PHI may be provided to various governmental or accreditation entities such as the Joint Commission on Accreditation of Healthcare Organizations to maintain our license and accreditation. In addition, PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of the Facility and Health Professionals.

Additionally, your PHI may be used or disclosed for the purpose of allowing students, residents, nurses, physicians and others who are interested in healthcare, pursuing careers in the medical field or desire an opportunity for an educational experience to tour, shadow employees and/or physician faculty members or engage in a clinical Practicum.

Health Information Organizations. Your PHI may be used and disclosed with other health care providers or other health care entities for treatment, payment and health care operations purposes, as permitted by law, through a Health Information Organization. A list of Health Information Organizations in which this facility participates may be obtained upon request or found on our website at www.uspi.com. For example, information about your past medical care and current medical conditions and medications can be available to other primary care physicians if they participate in the Health Information Organization. Exchange of health information can provide faster access, better coordination of care and assist providers and public health officials in making more informed treatment decisions. You may opt out of the Health Information Organization and prevent providers from being able to search for your information through the exchange. You may opt out and prevent your medical information from being searched through the Health Information Organization by completing and submitting an Opt-Out Form to registration.

Use or Disclosure for Directory of Individuals in the Facility. Facility may include your name, location in the Facility, general health condition and religious affiliation in a patient directory without obtaining your authorization *unless* you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or minister, even if they do not ask for you by name. If you do not wish to be included in the facility directory, you will be given an opportunity to object at the time of admission.

Disclosure to Relatives, Close Friends and Other Caregivers. Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you who is involved in your health care or helps pay for your care. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the

Facility and/or Health Professionals may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, the Facility and/or Health Professionals would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Health Oversight Activities. Your PHI may be disclosed to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. For example, your PHI may be disclosed to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the facility.

Correctional Institution. You PHI may be disclosed to a correctional institution if you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain requests to us.

Organ and Tissue Procurement. Your PHI may be disclosed to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Research. Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board approves a waiver of authorization for disclosure.

Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

U.S. Military. Your PHI may be use or disclosed to U. S. Military Commanders for assuring proper execution of the military mission. Military command authorities receiving protected health information are not covered entities subject to the HIPAA Privacy Rule, but they are subject to the Privacy Act of 1974 and DoD 5400.11-R , "DoD Privacy Program," May 14, 2007.

Other Specialized Government Functions. Your PHI may be disclosed to units of the government with special functions, such as the U.S. Department of State under certain circumstances for example the Secret Service or NSA to protect the country or the President.

Workers' Compensation. Your PHI may be disclosed as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of a medical device.

Appointment Reminders. Your PHI may be used to tell or remind you about appointments.

Fundraising. Your PHI may be used to contact you as a part of fundraising efforts, unless you elect not to receive this type of information.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Use or Disclosure with Your Authorization. For any purpose other than the ones described above, your PHI may be used or disclosed only when you provide your written authorization on an authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before your PHI can be sent to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

Marketing. Your written authorization ("Your Marketing Authorization") also must be obtained prior to using your PHI to send you any marketing materials. (However, marketing materials can be provided to you in a face-to-face encounter without obtaining Your Marketing Authorization. The Facility and/or Health Professionals are also permitted to give you a promotional gift of nominal value, if they so choose, without obtaining Your Marketing Authorization). The Facility and/or Health Professionals may communicate with you in a face-to-face encounter about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without Your Marketing Authorization.

In addition, the Facility and/or Health Professionals may send you treatment communications, unless you elect not to receive this type of communication, for which the Facility and/or Health Professionals may receive financial remuneration.

Sale of PHI. The Facility and Health Professionals will not disclose your PHI without your authorization in exchange for direct or indirect payment except in limited circumstances permitted by law. These circumstances include public health activities; research; treatment of the individual; sale, transfer, merger or consolidation of the Facility; services provided by a business associate, pursuant to a business associate agreement; providing an individual with a copy of their PHI; and other purposes deemed necessary and appropriate by the U.S. Department of Health and Human Services (HHS).

Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental illness, mental retardation and developmental disabilities; (3) is about alcohol or drug abuse or addiction; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about communicable disease(s),

including venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult; or (9) is about sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, the Facility and Health Professionals are not required to agree to these requested restrictions.

You may also request to restrict disclosures of your PHI to your health plan for payment and healthcare operations purposes (and not for treatment) if the disclosure pertains to a healthcare item or service for which you paid out-of-pocket in full. The Facility and Health Professionals must agree to abide by the restriction to your health plan EXCEPT when the disclosure is required by law.

If you wish to request additional restrictions, please obtain a request form from the Health Information Management Office and submit the completed form to the Health Information Management Office. A written response will be sent to you.

Right to Receive Confidential Communications. You may request, and the Facility and Health Professionals will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the Facility and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Facility Health Information Management Office identified below.

Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by the Facility and Health Professionals in order to inspect and request copies of the records. Under limited circumstances, you may be denied access to a portion of your records. If you desire access to your records, please obtain a record request form from the Facility Health Information Management Office and submit the completed form to the Facility Health Information Management Office. If you request copies of paper records, you will be charged in accordance with federal and state law. To the extent the request for records includes portions of records which are not in paper form (e.g., x-ray films), you will be charge the reasonable cost of the copies. You also will be charged for the postage costs, if you request that the copies be mailed to you. However, you will not be charged for copies that are requested in order to make or complete an application for a federal or state disability benefits program.

Right to Amend Your Records. You have the right to request that PHI maintained in your medical record file or billing records be amended. If you desire to amend your records, please obtain an amendment request form from the Facility Health Information Management Office and submit the completed form to the Facility Health Information Management Office. Your request will be accommodated unless the Facility and/or Health Professionals believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, you will be charged for the accounting statement.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Privacy & Security

Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy & Security Compliance Office will provide you with the correct address for the Director. The Facility and Health Professionals will not retaliate against you if you file a complaint with the Privacy & Security Compliance Office or the Director.

Effective Date and Duration of This Notice

Effective Date. This Notice is effective on March 1, 2021.

Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that the Facility and Health Professionals maintain, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas around the Facility and on our Internet site at *www.uspi.com*. You also may obtain any new notice by contacting the Privacy & Security Compliance Office.

FACILITY CONTACTS:

Southwestern Ambulatory Surgery Center
Privacy & Security Compliance Office
14201 Dallas Parkway
Dallas, Texas 75254
E-mail: PrivacySecurityOffice@tenethealth.com
Ethics Action Line (EAL): 1-800-8-ETHICS

Swasc-docs/forms/privacy3.1.2021