Squaw Peak Surgical Facility Patient Handbook

- What to bring to your appointment
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- Notice on Advanced Directives
- Helpful Information about billing
- Notice on HIPAA Privacy Act Statement
- Notice to Patients

1635 E. Myrtle Ave., Ste. 100

Phoenix, AZ 85020

Tel: 602.944.5656 Fax: 602.944.2727

www.sciatica.com

Welcome to SPSF

Welcome and thank you for choosing Squaw Peak Surgical Facility. Squaw Peak Surgical Facility (SPSF) is a state of the art medical facility offering the latest in technology ensuring that your physician and expert team of medical professionals have the tools they need to provide the absolute highest standard of care.

This patient handbook is designed to provide you with information about SPSF as well as provide us with information to best care for you. This packets also contains the patient's Bill of Rights, Financial Interests, and our HIPAA policy. If any of those documents are missing or you have questions about them please do not hesitate to call SPSF at (602) 944-5656 and we will make arrangements to send you additional copies and answer your questions. Please take a few minutes to read the handbook, complete the last page in its entirety, and bring the handbook with you on the day of your appointment. We will need the completed handbook prior to beginning your procedure.

We look forward to meeting you and providing you with excellent care. As always, please do not hesitate to call SPSF if you have any questions (602) 944-5656.

Please bring the following to your appointment:

- Your entire completed Patient Registration packet
- This Patient Handbook with the last page completed
- Insurance Card: We work with all insurance plans on a case-by-case basis. For insurance questions please call 602-216-6082.
- Any copay and/or deductible payment
- Photo identification
- Any MRIs, X-rays, CT scans and/or EMGs and the written report

Before your procedure:

- Obtain physician clearance to stop blood-thinners such as Coumadin, Plavix, etc. Please make sure that your physician faxes the clearance/instructions to our office (FAX 602-944-2727). Generally, you should stop Plavix 7 to 10 days prior to surgery, and stop Coumadin 5 days prior.
- For surgical procedures such as Microscopic Lumbar Discectomy/Selective Endoscopic Discectomy/ Endoscopic Rhizotomy/Fusions do not eat or drink anything including water, after midnight the night before surgery unless your doctor instructs you to take medicine(s) with a sip of water the day of surgery.
- For surgical procedures, discontinue the following at least 10 days prior to your surgery as they may cause excessive bleeding: Non-steroidal Anti Inflammatory Drugs (NSAIDs), including Advil (Ibuprofen), Aleve (Naproxen), Aspirin/Aspirin products, Vitamin E, Ginseng, Fish Oil supplements, and Gingko Biloba.
- For interventional pain injection procedures, you may eat a light meal prior to your appointment.
- Have someone available to drive you home, and preferably stay with you for a few hours. (For an evocative discography you will need a driver to take you to the CT scan immediately following the procedure.)
- Wear loose, comfortable clothing that is easily removed.
- Leave all valuables and jewelry at home. SPSF will not be responsible for any loss of your belongings.
- Bring glasses with a case. Do not wear contact lenses.
- Please visit www.sciatica.com for further information regarding your procedure.

Patient Bill of Rights & Responsibilities

Each patient has the right:

- To considerate and respectful care.
- To obtain from his/her physician complete current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.
- To participate in decisions involved in his/her care and to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment.
- To know the name of the person responsible for the procedure and/or treatment.
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action.
- To every consideration of his/her privacy concerning his/her medical care.
- To expect that all communications and records pertaining to his/her care, including financial records, should be treated as confidential and not released without written authorization by the patient.
- To obtain information as to any relationship of this facility to other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by names, which are treating him/her.
- To know if research will be done and the right to refuse to participate in such research projects.
- To expect reasonable continuity of care. The patient has the right to expect that this facility will provide a mechanism whereby he/she is informed by his/her physician of the patient's continuing health care requirements following discharge.
- To examine and receive an explanation of his/her bill regardless of the source of payment and to be informed regarding the fees for procedures performed in the center. The patient has a right to be informed of third party coverage including Medicare and Arizona Health Care Cost Containment System.
- To know what facility rules and regulations apply to his/her conduct as a patient.
- To file a patient complaint or grievance with the Administrator at (602) 944-2900, or by mail at SPSF, 1635 E. Myrtle Ave., Ste. 100, Phoenix, AZ 85020, or with the AZ Dept of Health Services at (602) 364-3030, or visit www.azdhs.gov, or write to ADHS, 150 N. 18th Ave., Ste. 450, Phoenix, AZ 85007, or the Medicare Beneficiary Ombudsman at https://www.medicare.gov/claims-and-appeals/medicare-rights/gethelp/ombudsman.html. All complaints must be submitted in writing and will be reviewed within 60 days.
- To be free from chemical, physical, psychological abuse or neglect.
- To timely and appropriate pain management.
- To choose where to receive services, including a facility where his/her physician does or does not have an ownership interest.

Each patient has the responsibility:

- To read and understand all documents, consents and authorizations. If you do not understand, it is your responsibility to ask the nurse or physician for clarification.
- To fully participate in decisions involving his/her own health care and to accept the consequences of these decisions if complications occur.
- To provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and allergies and sensitivities.
- To provide a responsible adult to transport him/her home from the facility.
- To read the Advance Directive notice below.
- To assure all financial obligations for services are fulfilled as promptly as possible and to assume ultimate responsibility for payment regardless of insurance coverage.
- To be respectful of all health care providers and staff, as well as other patients.
- To follow his/her doctor's instructions, take medication when prescribed, and ask questions concerning his/her own health care that he/she feels are necessary.
- To contact the physician or nurse regarding any post-operative questions or problems.

Advance Directive

Advance Directive is a general term that refers to your oral or written instructions about your future medical care in the event that you become unable to communicate those instructions. If you have an advance directive please provide SPSF with a copy of your advance directive, and notify your surgeon. SPSF will not honor DNR orders; if any patient requires emergency lifesaving support, SPSF will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. If you do not agree, you, your conservator or guardian will be given an opportunity to cancel the surgical procedure and we will be happy to assist you in rescheduling your procedure at another facility. If you wish additional information regarding advance directives, contact the Arizona Secretary of State Advance Directive Registry at www.azsos.gov/adv_dir.

SPSF Financial Policy

We strongly encourage you to contact us to make financial arrangements prior to your procedure, so that you may concentrate on your recovery. As a courtesy, we will bill your insurance company; however, you are financially responsible for any unpaid or underpaid charges. Please realize that your policy is a contract between you and the insurance company. Any required co-payments, deduction or non-covered services are beyond our control, and are your responsibility.

Payment is due at the time of service; any other arrangements must be made in advance. We accept cash, personal checks (with proper identification), MasterCard, Visa, American Express, and Discover. There is a $50.00 charge for non-sufficient funds and 10% interest compounded monthly for unpaid balances over 90 days.

All new patients must sign all required forms before seeing the doctor. In addition to your insurance information, we will need copies of your insurance card(s) and driver's license.

If you prefer to file your own insurance, or if your insurance company will not make payment directly to the provider, we require payment in full at the time of each visit. If you are cash pay, pre-payment is required. ***Additional charges may be required at the end of your visit***.

MEDICARE: We are participating Medicare providers and accept assignment. You are responsible for your annual deductible plus 20% of allowed charges due at the time of service unless you have a supplemental Medicare policy. Federal law requires us to collect these payments.

MEDICARE SUPPLEMENTS: We are able to file most supplemental policies for you; however, some companies will not pay us directly. In those cases, payment is due at the time of service.

WORKER'S COMPENSATION: If you have an open, accepted Worker's Compensation claim, you are required to provide us with all necessary insurance information. For ***out of state Workers Compensation claims***, your claims adjustor will need to provide written authorization prior to your scheduled appointment. Payment is accepted under The Industrial Commission of Arizona fee schedule only.

PPO/HMO PLANS: If we are contracted with your insurance company, your co-payment is due prior to being seen by the doctor. For in or out of network insurance coverage, your ***deductible and any estimated co-insurance is due prior to any office visit or procedure***. You will be sent a statement for any remaining balance that is your responsibility. This balance is due and payable upon receipt.

AHCCCS/MEDICAID: SPSF is NOT CONTRACTED with ANY AHCCCS or STATE MEDICAID PLANS. By signing below, you agree to pay in advance all charges related to your treatment. Unless you have Medicare as primary coverage, we will not submit claims to AHCCCS or any other state Medicaid plan.

CHECKS FROM YOUR INSURANCE COMPANY: After your visit(s)/procedure(s) you may receive one or more checks and explanation of benefits directly from your insurance company as payment for the services provided. You are responsible for forwarding those payments and the explanation of benefits on to us. Please endorse and forward to our office for processing at 1635 E. Myrtle Ave., Phoenix, AZ 85020. If a claim(s) need to be appealed we will assist with these appeals; however, at times we may need your help in calling your insurance company to process the claim correctly.

FORMS: Disability/FMLA or other forms requiring physician/staff review for completion will require a payment of $40.00 for the first page, $5.00 for each additional page.

PERSONAL INJURY OR AUTO ACCIDENT CLAIMS: Unless we have a signed lien on file, you are responsible for payment at the time of service. If applicable, we will bill your private medical insurance. If we are contracted with your insurance plan, there may be a difference between what we bill and what the insurance company allows. When there is a third party claim, most insurance plans allow us to balance bill the patient.

LAB/X-RAY: If we order laboratory tests or special x-rays that are not taken in our office, you will be billed directly by the lab or x-ray facility. You are responsible for payment of that bill. If your insurance company requires for you to go to a particular facility, please let us know. Please advise us if your insurance company requires pre-certification/authorization for tests, x-rays, surgeries, physical therapy, etc.

UNDERSTANDING YOUR CHARGES: Here is a brief explanation of the possible charges that you may receive following a procedure at SPSF:

Surgery Center Charge: This fee is for the staff and equipment we provide for your safe and successful experience here. Questions and payments regarding your surgery center billing should be addressed to our office.

Physician: Your procedure will be performed by a surgeon. Since this physician is not an employee of our surgical center, he/she will bill you separately for your procedure. The physician's bill, along with any questions pertaining to it must be addressed by their office.

Anesthesiologist: If you receive anesthesia from an anesthesiologist during your procedure, you will receive a separate bill for these services as well. You must address all questions and send all payments to their respective billing group. Please call National Partners in Healthcare at 480-820-0627.

DME = braces

We believe that communication with our patients regarding our financial policy assists us in providing the best service to you. If you have any questions regarding our financial policy, please let us know.

Privacy Act Statement

To our patients**:** This notice describes how your Protected Health Information (PHI) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996(HIPAA). Our practice is dedicated to maintaining the privacy of your PHI. We are required by law to maintain the confidentiality of your PHI. This notice is to provide you with our legal duties and privacy practices, which we agree to abide by the terms of the notice currently in effect. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that it maintains, any revised notices will be posted here and available for your request at our front desk and available on our website www.sciatica.com.

With your written consent our practice may use and disclose your PHI in the following ways:

- In order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI information to others who assist in your care, such as your spouse, children, or parents, in compliance with the State and National Laws.
- To bill and collect payment for the services you receive from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. We may use and disclose this information to obtain payment from third parties that may be responsible for such costs. We may use your PHI to bill you directly for services, supplies, medical records, and any other requested items.
- To be able to run our practice at the highest standards, as effectively as possible. This could be used to evaluate the performance of services provided to insure complete Quality Assurance procedures and policies.
- When we are required to do so by Federal, State, or local laws.
- We may need to call you by phone to remind you of an appointment, to return a patient phone call, or leave a message. Please advise us if you do not want us to call or leave any messages for you on a voicemail, answering machine, or with any answering parties at your listed contact phone number.

Certain circumstances may require us to use or disclose your PHI without your consent, below are examples:

- To the Public Health Authorities and Health Oversight agencies that are authorized by law to collect information.
- Lawsuits and similar proceedings in response to a court or administrative order.
- If required to do so by a Law Enforcement Official.
- When necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
- If you are a member of United States, or Foreign Military Forces (includes Veterans) and if required by the appropriate authorities.
- To Federal Officials for intelligence and National Security activities authorized by law.
- Correctional Institutions or Law Enforcement Officials if you are an inmate, or under the custody of a Law Enforcement Official.
- To Workers Compensation carriers.
- If you are an Organ Donor, as necessary to facilitate the organ or tissue donations and transplantation.
- To authorized Federal Officials so they may provide protection to the President, other authorized persons or foreign heads of State or conduct special investigations.
- To a coroner or medical examiner.
- For research.

Your written authorization is required in the following circumstances:

- To release any PHI to an attorney, any insurance company that is not currently your medical insurance carrier, or if you are changing physicians.
- If you provide us permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. If you revoke your permission that was obtained as a condition of obtaining insurance coverage, other law still allows the insurance company to contest a claim under the policy.
- To use or sell your PHI for marketing purposes.
- To restrict disclosures to a health plan for a health care item or service you have paid for out of pocket in full.
- To restrict disclosures to a family member or other involved in your care after your death.

Privacy Act Statement cont.

You have the right to request a restriction or limitation on the medical information we use or disclose about you : for treatment, payment, or health care operations. **We are not required to agree to your request**. If we do agree, we will comply with your request unless the PHI is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to Desert Institute for Spine Care, Attn: Administrator. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example disclosures to your spouse.

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 at work or by mail. To request confidential communications, you must make your request in writing to Squaw Peak Surgical Facility, Attn: Administrator. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted, and must contain a statement that disclosure of all or part of your medical information that you are requesting to be communicated to you in a certain way or at a certain location could endanger you.

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include information compiled in anticipation of a legal proceeding or psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Squaw Peak Surgical Facility, Attn: Administrator. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request and will provide you with access and/or copies within 30 days.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

If you feel the medical information about you is incorrect or incomplete, you have the right to ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our Practice. To request an amendment, your request must be made in writing to Squaw Peak Surgical Facility, Attn: Medical Assistant. In addition, you must provide a reason that supports your request. We have 60 days to respond.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the PHI kept by or for the Practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

You have the right to request an "accounting of disclosures." This is a list of the discourses we have made of medical information about you. You must request this list in writing to Squaw Peak Surgical Facility, Attn: Administrator. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before costs are incurred.

You have a right to restrict certain disclosures of PHI to a health plan where you have paid out of pocket in full for that health care item or service.

You have a right to a paper copy of this notice that is available at front desk or may be printed from the website www.sciatica.com.

We reserve the right to change this notice.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the Administrator at (602) 944-2900, or with the AZ Department of Health Services at (602) 364-3030, or visit www.azdhs.gov, or write to ADHS, 150 North 18th Avenue, Ste. 450, Phoenix, AZ 85007, or the Medicare Beneficiary Ombudsman at https://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

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Notice to Patients

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A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(ff). We support this law, because it helps patients make reasoned financial decisions concerning their medical care. In compliance with the requirements of this law, you are being advised we have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services we prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

Dr. Christopher Yeung has part ownership and/or a direct financial interest in Desert Institute for Spine Care PC, Squaw Peak Surgical Facility Inc, Arizona Recovery Care Center LLC, The CORE Institute Specialty Hospital, Surgical MRI, and CKY Corporation. He makes investments, receives royalties, and/or consults in Globus Medical Inc, Bonovo Orthopedics, Plasmology 4 Inc, Lattice Biologics Ltd, Electro Core LLC, Subchondral Solutions Inc, Helia Care Inc, Elliquence, Verve Medical, Arthrex, inFormed Consent, Amplify Surgical, and Spineology.

Dr. Justin Field has part ownership and/or a direct financial interest in Desert Institute for Spine Care PC, Squaw Peak Surgical Facility Inc, Arizona Recovery Care Center LLC, The CORE Institute Specialty Hospital, SurgCenter Camelback, Arizona Specialty Hospital, and Excel Pharmacy. He makes investments, receives royalties, and/or consults in Precision Spine, RTI Surgical, Helia Care Inc, Mobius Imaging LLC, Nuvasive, Plasmology 4 Inc, Additive Implants, Innovasive, Omnia Medical, and CoreLink Medical Device.

Dr. Nima Salari has part ownership and/or a direct financial interest in Desert Institute for Spine Care PC, Squaw Peak Surgical Facility Inc, Arizona Recovery Care Center LLC, Arizona Health Associates LLC, The CORE Institute Specialty Hospital, SurgCenter Pima Crossing, Excel Pharmacy, RxToME LLC, and Arizona Specialty Hospital. He makes investments, receives royalties, and/or consults in Mobius Imaging LLC, White Coat Consulting PLLC, Medacta USA Inc, Omnia Medical, Plasmology 4, Stryker Spine, Globus Medical, Helia Care Inc, DePuy Synthes, Verve Medical, Dot Technology LLC, and HOPCo.

Dr. Joshua Abrams has part ownership and/or a direct financial interest in Desert Institute for Spine Care PC, Squaw Peak Surgical Facility Inc, SurgCenter North Phoenix, The CORE Institute Specialty Hospital, Arizona Specialty Hosptial and Excel Pharmacy. He makes investments, receives royalties, and/or consults in Designs and Services Hub, Omnia Medical, SurGenTec, and Stryker Corporation.

Dr. Mark Wang has part ownership and/or a direct financial interest in Squaw Peak Surgical Facility Inc, SurgCenter at Pima Crossing, Excel Pharmacy, Arizona Specialty Hospital and MJW Medical Consulting PLLC. He makes investments, receives royalties, and/or consults in Globus Medical Inc, Medacta USA Inc, Helia Care Inc, Amplify Medical, Verve Medical, Accelus & Xtant Medical.

ARE THESE SERVICES AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS? _X_ Yes ___ No

Services at the above listed facilities are available on a competitive basis at other hospitals where our physicians are on staff, including Scottsdale Healthcare Shea and Scottsdale Healthcare Thompson Peak. Multiple other healthcare companies offer the same equipment that may accomplish the goals of the equipment provided by the above healthcare companies listed. You are encouraged to ask any of our physicians their reasons for choosing instruments from the above listed companies, or any other instrument, in your treatment.

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file and you will receive a copy.

ACKNOWLEDGEMENT: I have read this “Notice to Patients” form, and I understand the disclosures that it contains.

Dated this __________Day of ________________, 20______

______________________________________ ______________________________________

Name of Patient/Legal Representative Signature of Patient/Legal Representative

Acceptance of SPSF Policies & Procedures

Patients, please read the following and sign below.

- My signature indicates that I have received and read the Squaw Peak Surgical Facility (SPSF) Patient Handbook containing the HIPAA Privacy Act Statement, Patient Bill of Rights, SPSF Financial Policy and SPSF "Notice to Patients" Ownership Disclosure, Consent to Treatment and Release of Liability, and Notice of Advanced Directives/Living Wills.
- I have had the opportunity to ask questions regarding the information in this handbook prior to signing this agreement.
- I understand and agree to abide by any and all of the rules and regulations contained in this handbook.

Name of Patient/Legal Representative	**Signature**	**Date**

Authorization to Pay

I request payment of authorized Medicare and/or insurance benefits to be made on my behalf to Squaw Peak Surgical Facility (SPSF) for any services provided for my care by their physicians/providers.

I authorize any holder of my medical information to release all information necessary to the Health Care Financing Administration/Center for Medicare/Medicaid Services, and other Insurance Companies I have listed, and its agents to determine benefits payable for medical treatment received at SPSF.

I authorize any holder of my medical information including Government, Medicare/Medicaid, Primary Care Physician, and Insurance companies to release all information necessary to determine benefits payable for medical treatment received at SPSF.

Name of Patient/Legal Representative	**Signature**	**Date**

Authorization to Use and Disclose Protected Health Information

I hereby permit Squaw Peak Surgical Facility (SPSF) to use and disclose my Protected Health Information (PHI) to any third party **payor**, or to any party involved in my health care. By signing this Authorization, I understand the following (1) I have the right to revoke this Authorization, by sending **written** notification to SPSF. Once SPSF receives the written revocation this Authorization will be revoked, except to the extent that SPSF has already taken action in reliance upon this Authorization; (2) Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law; (3) This Authorization shall be enforced as long as I am a patient of this practice. **Unless**, I give written notice to revoke my Authorization; and (4) I have a right to refuse to sign or revoke this Authorization as SPSF may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization.

Name of Patient/Legal Representative	**Signature**	**Date**

Consent for Release of Medical Information

I hereby authorize Squaw Peak Surgical Facility to convey to any physician and/or any medical facility directly involved with my care, my medical history, laboratory reports, x-rays, and any other material services, consultations, and treatments which I received while under his/her care.

Name of Patient/Legal Representative	**Signature**	**Date**