ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to Pacific Specialist Surgical Center, LLC dba Hayes Valley Surgery Center (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against and person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to Pacific Specialist Surgical Center, LLC dba Hayes Valley Surgery Center for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider and attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including the Law Offices of Cohen and Howard) or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name:_____ Date:_____

Patient Signature: _____

CONSENT TO MEDICAL BILLING AND APPEAL

1. I, the undersigned, certify that I (or my dependent) have insurance with the above listed carriers, and assign directly to Hayes Valley Surgery Center ("HSC") all insurance benefits, if any, otherwise payable to me for services rendered. I hereby expressly assign my rights and benefits under ERISA, including, but not limited to penalty provisions and all relief permitted pursuant to section 1132 of ERISA to HSC. I understand that I am financially responsible for all charges whether or not paid by the insurance carrier(s). I hereby authorize the doctor and facility to release all information necessary to secure payment of benefits. In addition, in the event that any insurance payments are made directly to me or my dependent (the patient or subscriber) by my insurance carrier for services provided to me by HSC (i.e., my insurance carrier sends a check directly to me instead of HSC), I acknowledge and agree that I will immediately deliver to HSC the check and that I will endorse the check and make it payable to HSC. I authorize the use of this signature on all insurance submissions.

2. I hereby authorize Hayes Valley Surgery Center ("HSC") to appeal the determination made by my insurance company on my behalf, as my Designated Representative, and, as part of the appeal, I hereby authorize in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism, drug abuse, abortion, mental disorder and **HIV** status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released and specified in this authorization, or as required or permitted by law. This authorization is valid until otherwise revoked in writing.

3. Please check the box that applies to you:

☐ No, I do not have a secondary medical insurance policy

☐ Yes, I have a secondary medical insurance policy

Insurance Carrier: _____

Group#: _____

Subscriber ID #:_____

_____

Signature of Responsible Party/Member or Legal Guardian/Representative

Date:_____

PATIENT POLICY ON ADVANCE DIRECTIVES
PATIENT CONSENT TO RESUSCITATIVE MEASURES

All patients have a right to participate in their own healthcare decisions and to have 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.

Unlike an acute care hospital setting, the surgery center does not routinely perform high risk procedures. Most procedures performed in this surgery center are considered to be minimal risk. However, no surgery is without risk. You will discuss the specifics of your procedure with your physician who will answer your questions of risks, expected recover, and after care.

It is the policy of the surgery center, 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 your treatment a Hayes Valley Surgery Center, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. Your agreement with this policy by your signature below does not revoke or invalidate any current healthcare directive or healthcare power of attorney.

<u>If you do not agree with this policy, we will assist you in rescheduling your procedure.</u>
Please check the appropriate box in response to this question:

Have you executed an Advance Healthcare Directive, a Living Will, or a Power of Attorney that authorizes someone to make healthcare decisions for you?

- ☐ Yes, I have an Advance Directive, Living Will, or Healthcare Power of Attorney.
- ☐ No, I do not have and Advance Directive, Living Will, or Healthcare Power of Attorney.
- ☐ I would like to have information on Advance Directives

If you checked "Yes", please provide the surgery center with a copy of the document so that it may be added to your medical record.

I acknowledge that I have read, understand, and agree to the Advance Directive Policy.

_____ _____
Patient Signature Date

If consent to the procedure is provided by someone other than the patient, the person providing consent must sign below.

I acknowledge that I have read, understand, and agree to the Advance Directive Policy.

_____ _____
Signature Date

_____
Printed Name

Relationship to Patient ___ Court Appointed Guardian ___ Attorney in Fact
___ Healthcare Surrogate ___ Other _____

HAYES VALLEY SURGERY CENTER

Billing Practices

Hayes Valley Surgery Center will bill your insurance company for your procedure today. The amount calculated today is an estimate based on what was scheduled by your surgeon. This amount may change based on what is performed. The facility may or may not be contracted with your carrier. Once you receive your Explanation of Benefits, you may have questions about what is owed. Please call the surgery center to discuss your Explanation of Benefits and any necessary adjustments or arrangements may be made at that time between Hayes Valley Surgery Center and you.

You may have a greater financial responsibility for services provided by health care professionals at Hayes Valley Surgery Center who are not under contract with your health care plan.

You have the right to have the services performed at another surgery center which offers the same or similar services. If you are interested in having your services performed at another surgery center, please let us know and we can provide you with information about alternative facilities.

Please do not contact your referring physicians to discuss your bills with the surgery center. Please call Hayes Valley Surgery Center at 415-821-8015.

Initials Required

____ Patient received copy of HVSC billing practices.

INSURANCE PAYMENT

Date: _____

Patient: _____ Patient ID Number:_____

In the event that your insurance company directs payment to you for services rendered, you are responsible for forwarding it to our office as soon as possible.

This payment is not a refund in any way towards your services and should not be withheld from the surgery center.

If you receive payment directly and choose not to forward it, you will be fully responsible for all services rendered

Agreed and accepted by:

_____
Signature of Patient or Guardian

_____
Printed Name

Date: _____

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.

The Health Insurance Portability & Accountability Act of 1996, HIPAA, is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used effective 4/13/03. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example of this would be an internal quality assessment review.
- We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.
- The right to lodge a complaint with the Privacy Officer.

PATIENT RIGHTS

Patient Rights and Responsibilities were established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, family, physician and the facility caring for the patient. Patients have the following rights without regards to age, race, sex, national origin, religion, culture, or physical handicap.

The Federal Government requires that you be informed of these rights prior to the day of your procedure. This completed and signed form must be present at the time of your admission to the surgery center.

THE PATIENT HAS A RIGHT TO:

- Receive the care necessary to help regain or maintain his or her maximum state of health.
- Expect personnel who care for the patient to be friendly, considerate, respectful, and qualified through education and experience and perform the services for which they are responsible with the highest quality of service.
- Expect full recognition of individuality, including personal privacy in treatment and care. All communications and records will be kept confidential.
- Complete information, to the extent known by the physician, regarding diagnosis, treatment, and prognosis, as well as alternate treatments or procedures and the possible risks and side effects associated with treatment.
- Be a participant in the decisions regarding the intensity and scope of treatment. This includes the right to request or fuse treatment.
- Be fully informed of the scope of services available at the facility, provisions for after hours and emergency care.
- Receive information in a manner that the patient can understand. Communication with the patient will be effective and provided in a manner that facilitates understanding by the patient.
- Have knowledge of the names of the physician who has primary responsibility for coordinating his or her care and the names of other professional relationships of other physicians and healthcare providers who will see him or her. The patient has a right to change providers if other qualified providers are available.
- Be advised I, the physician, has/has not a financial interest in the surgery center.
    - ☐ Physician has financial interest in the surgery center.
    - ☐ Physician does not have financial interest in the surgery center.

You have the right to have the services performed at another surgery center, which offers the same or similar services. If you are interested in having your services performed at another surgery center, please let us know and we can provide you with information about alternative facilities.

- Have all patient rights apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.
- Approve or refuse the release of medical records to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or a third-party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care or treatment and can refuse participation in such without compromise to the patient's usual care.
- Be informed of the facility's policy regarding advanced directives and living wills. See attached.
- Access to copies of his or her individual medical record within a reasonable amount of time.
- Receive an explanation of bill and fees involved.

- Express those spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of medical therapy.
- Have initial assessment and regular reassessments of pain.
- Education of patient and families, when appropriate, regarding their roles in managing pain, as well as potential limitations and side effects of pain treatment.
- Be advised of the facility's grievance process should the patient wish to communicate a concern regarding the quality of care received. Contact Facility Administrator.
- Be advised of the contact information for the state agency to which complaints can be reported, as well as contact information for the Office of Medicare Beneficiary Ombudsman. Health Service Advisory Group at www.hsag.com or 818-409-9229. Or go to www.medicare.gov. TTY users should call 1-877-486-2048 or visit the Ombudsman's website at www.cms.hhs.gov/center/ombudsman.asp. California Department of Public Health, Licensing and Certification Program:

San Francisco District Office
150 N. Hill Drive
Suite 22
Brisbane, CA 94005
Phone: 415-330-6353
Fax: 415-330-6350

San Jose District Office
100 Paseo de San Antonio,
Suite 235
San Jose, CA 95113
Phone: 408-277-1784
Fax: 408-277-1032

PATIENT RESPONSIBILITIES:

- Provide caregivers with the most accurate and complete information regarding present compliant, past illnesses, hospitalizations, medications, unexpected changes in patient's condition or any other patient health matters.
- Provide a responsible adult to provide transportation for him or her from the facility to home and to stay for 24 hours.
- Observing rules of the facility during his or her stay. Following the treatment plan established by the physician, including the instructions of nurses and other healthcare professionals.
- Be considerate of other patients and personnel and respecting the property of others and the facility.
- Reporting whether or not he or she understands the planned course of treatment and what is expected of him or her.
- Promptly fulfilling his or her financial obligations to the facility.

Signature confirms notification of patient rights and responsibilities.

_____ _____

☐ Patient Signature ☐ Patient Representative Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*

You may refuse to sign this acknowledgement

Hayes Valley Surgery Center will use and disclose your personal health information to treat you. To receive payment for the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information.
The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution.

I,_____, have received / declined a copy of this facilities Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Official Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement
Other (please specify):

YOU ARE ENTITLED TO A COPY OF THE CONSENT AFTER YOU SIGN IT.
Include completed consent in the patient's Medical Record

Patient Questionnaire

The California Health and Safety Code (Section 128737) requires that we collect and submit race and ethnicity information to the Office of Statewide Health Planning & Development beginning January 1st, 2005. **Please complete the following:**

1 What is your Race and Ethnicity:

Race:

- ☐ American Indian (R1)
- ☐ Asian (R2)
- ☐ Black/African American (R3)
- ☐ Native Hawaiian/Pacific Islander (R4)
- ☐ White (R5)
- ☐ Other Race (R6)
- ☐ Unknown (R7)

Ethnicity:

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

2 Is this procedure due to an injury you sustained?

No, there are no more questions, thank you.

Yes, please continue.

If yes. How did your injury occur?

_____

_____

Where were you when you sustained your injury? (at home, driving to work, on a soccer field, etc…)

_____

_____