UROLOGY SPECIALISTS

Patient Sticker

Ambulatory Surgical Center, Prof. LLC

PATIENT NOTIFICATION & ACKNOWLEDGEMENT

Notice of Rights & Responsibilities

USC Ambulatory Surgical Center, Prof. LLC has established a Patient's Bill of Rights and Responsibilities, which is provided verbally and in writing in a language and manner the patient or patient's representative understands prior to a procedure. It is expected that observance of these rights will contribute to more effective patient care and greater satisfaction for patients, physicians and the Surgical Center.

Notice of Privacy Practices

USC Ambulatory Surgical Center, Prof. LLC will disclose your personal health information (PHI) only in those situations necessary to provide you safe and effective treatment, to receive payment for the care you receive in our facility, and for other healthcare operations as deemed necessary. A description of how your PHI will be used is summarized in the patient privacy notice which is posted in the Surgical Center.

I give permission for my protected health information (PHI) to be disclosed for purposes of communicating results, findings and care decisions to family members and others.

❑ Yes ❑ No ❑ Limited disclosure to persons listed below:

Name: _____ Date: _____

Name: _____ Date: _____

Financial Disclosure

USC Ambulatory Surgical Center, Prof. LLC is privately owned and has informed the patient prior to the date of the procedure that their physician may have a proprietary interest in this facility. The patient has the right to choose the facility of his/her choice for health related services.

Financial Disclosure

It is the policy of USC Ambulatory Surgical Center, Prof. LLC, regardless of any advance directives or instructions from a health care surrogate or power of attorney, that an unexpected medical emergency, which occurs during treatment at this facility, will be aggressively managed with resuscitative or other stabilizing measures followed by emergency transfer to the closest emergency room. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or health care power of attorney. Acknowledgement of this policy does not revoke or invalidate any current health care directive or power of attorney. Please check the appropriate boxes below.

❑ Yes, I have an advance health care directive, living will and/or power of attorney.
❑ I have provided my advance health care directive, living will and/or power of attorney to USC Ambulatory Surgical Center, Prof. LLC.
❑ No, I do not have an advance health care directive, living will and/or power of attorney.
❑ I would like additional information on advance health care directives.

By signing this document, I acknowledge that the above information was given to me prior to my day of surgery, and that I have read and understand the information on the notice of patient rights and responsibilities, patient privacy practices, financial disclosure and advance directives. I agree to the policies of USC Ambulatory Surgical Center, Prof. LLC. If I have indicated I would like additional information, I acknowledge receipt of that information.

_____ _____

Patient Signature (If patient unable to sign, indicate relationship.) Date

_____ _____

Witness Signature Date