23390 W. Yuma Rd, STE. 106
Buckeye, AZ 85326
623-250-4800

PACKET ACKNOWLEDGMENT

Welcome! You have been scheduled to have surgery performed at Buckeye Surgery Center.

Attached is a packet of information that will need your attention. Please take a moment to **read, understand, complete, and sign** these forms prior to your surgical visit with us.

- Packet Acknowledgment
- Mission Statement and Important Information
- Transportation Policy
- Pre-Op Phone Call
- Medical Reconciliation
- Tuberculosis Questionnaire
- Insurance and Anesthesia Billing Information
- Advance Directive Statement
- Advance Directives Acknowledgment
- Notice of Direct Interest
- Notice of Privacy Practices (HIPPA)
- Patient Rights and Responsibilities

I acknowledge that I am in receipt of the above listed forms prior to my surgery and I understand that it is my responsibility to read, understand, complete, and sign and return the attached copy on my surgical day.

_____ _____

Patient/Legally Authorized Representative Signature Date

Mission Statement

To create a safe physical environment in preparation for the scheduled procedure, during the procedure, and immediately following the procedure.

To provide an atmosphere of compassion and understanding with minimal stress and anxiety.

To function at a high level of efficiency to accommodate the convenience of both the patient and the physician.

To assist the physicians in accomplishment of a plan of diagnostic and surgical treatment for each patient.

To promote knowledge and skills of the center's staff as a means of meeting technical and scientific progress in the delivery of health care and to be aware of new research, new products, and new ideas which may modify and improve present activities and procedures.

To maintain that all information regarding patients is kept private and confidential.

IMPORTANT INFORMATION

Buckeye Surgery Center
23990 W. Yuma Rd, STE 106
Buckeye, AZ 85326
623-250-4800

Date of Surgery: _____

Check-In Time: _____

- **Masks are required at all times while in the Surgery Center**
- **No cell phone use within the facility.**
- **Do not eat or Drink anything 8 hours prior to your surgery!**
- **Bring a Photo ID that includes your current address.**
- **Bring your Medicare and/or other insurance cards.**
- **Bring a copy of your living will and/or Medical Power of Attorney, if you have one.**
- **Please come prepared to pay your deductible, copayment and/or coinsurance.**
- **Bring the completed health history questionnaire.**
- **Medication List and the daily dosages.**
- **Arrange for transportation home**.
- A **responsible adult will need to drive you home.** Please tell the individual to be prepared to wait approximately 2-4 hours.
    - ***During this time, we are asking that all visitors wait in their vehicle during your surgery.***
- For your safety and comfort, we ask that you plan to have a responsible adult remain with you for several hours after your discharge.
- **Leave all valuables and jewelry at home.**
- **Avoid using facial or eye makeup on the day of your surgery.**
    - Artificial eyelashes must be removed.
- **Bring sunglasses.**

You may leave dentures and hearing aids in place. You will be asked to remove your hearing aid if it is on the operative side.

BUCKEYE Surgery Center

Transportation Policy

If you receive topical or local anesthesia with minimal or moderate sedation during your visit today, it is our policy that you have a responsible adult available to transport you home or accompany you in a taxi following your procedure or surgery. We also recommend you have a responsible adult available for twenty-four (24) hours after your surgery. Please list the person(s) in whose care you are being discharged today.

Name: _____

Phone: _____

I acknowledge that I understand and agree to the above transportation policy.

_____ _____

Patient/Legally Authorized Representative Signature Date

I, the patient, understand the above stated policy of this facility requiring a responsible adult to transport me home or accompany me if I am using a taxi or transportation service. I, however, for the reason listed below, do not have anyone that can accompany me and, therefore, must rely on a taxi or transportation service and understand the risks of not having someone accompany me home.

Reason:

_____

_____

_____ _____

Patient/Legally Authorized Representative Signature Date

I understand this patient does not have a responsible adult to accompany them home and will be discharged to an adult driver of a taxi or other transportation service.

_____ _____

Patient/Legally Authorized Representative Signature Date

BUCKEYE Surgery Center

Pre-Operative Call Record

PATIENT NAME: ❑Male ❑Female	**CONTACT INFORMATION**: best phone # to reach patient Phone #:_____ Type:_____ Alternate #:_____ Type:_____

DATE OF SURGERY:	Scheduled Surgery Time:	Scheduled Arrival Time:
Surgeon:	Type of Anesthesia:	
Scheduled Operation:		
Birthdate: Age:	Height:	Weight:
Patient has Advanced Directives: □Yes □No	Advised patient to bring copy to the Center: □Yes □No	Info given: ❑Yes ❑No
Patient has received a copy of the Patient Rights/Grievance Procedure/Disclosure of Ownership/Advance Directive Info: □Yes □No		
CURRENT MEDICATIONS AND ALLERGIES - **REFER TO MEDICATION RECONCILIATION LIST**		

PAST MEDICAL HISTORY	Y	N	N/A	PAST MEDICAL HISTORY	Y	N	N/A
Myocardial Infarction				Vision Disorder Glaucoma Blind			
Hypertension				Antibiotics before dental work			
MVP Heart Murmur Heart Valve Replacement				Hearing Loss			
Palpitations Arrhythmias Atrial Fib. CHF				LMP:			
Pacemaker AICD				History of emotional problems			
Chest Pain Angina				Alcohol use Amt./day:			
Asthma Emphysema SOB Home O_2				Smoking history: # of Years: PPD:			
Sleep Apnea □Yes □No				Use of street drugs			
CPAP □Yes □No				Mobility limitations			
Tuberculosis				Do you feel safe in your home environment?			
Stroke				Any cultural / religious / spiritual concerns			
Seizure Disorder				Chronic Pain 0-10 #____ Where?			
Diabetes type: □I □ II Hypoglycemia				Any nutritional needs/special diet:			
Thyroid Disorder				Any problems with falling?			
Bleeding Disorder Blood Clots				Spoken language:			
Kidney Disorder Patient on Dialysis: how often?				Other Medical Problems:			
Hepatitis Liver Disorder				**PAST SURGERIES**	**DATE**		
Esophageal Stricture Dysphagia Unexplained Weight Change							
Hiatal Hernia Acid Reflux Ulcer Heartburn N/V							
Cancer/Location/When:				**RECENT TESTS**			
Exposure to Infectious Disease AIDS Herpes STD's MRSA VRE C-Diff Treated: _____				Primary Care Physician:			
Recent UTI Flu Fever URI				Labs: Where:			
Arthritis				Last CXR: Last EKG:			
Skin Disorder / Current Rash				Stress Test: Cardiac Cath:			

Patient/Family history of problems with anesthesia/sedation/analgesia: □ Yes □ No If yes, describe:

PRE-OP INSTRUCTION GIVEN AND VERBALIZES UNDERSTANDING

□ Leave valuables at home, money / credit cards	□ Escort's Name:	□ Take routine AM meds
□ Bring insurance card/photo ID / Med. list	□ Escort will remain at facility	□ Do not take any diuretics
□ Wear loose, comfortable clothes	□ Bring Inhaler (if applicable)	□ Insulin instruction
□ Remove contacts / bring glasses	□ Plain water until 2° prior to arrival time	□ Light meal prior to 0600
□ Remove jewelry / make-up / lotion / nail polish	□ NPO after midnight	□ Light meal prior to 0700

□ COVID – 19 Questionnaire reviewed	□ Masks are required at all times while in the Surgery Center
Person interviewed:	□ Directions to facility
Reviewed by anesthesia: □Yes □No □N/A	NOTES:

RN signature:	Date:	Time:

BUCKEYE Surgery Center

Medication Reconciliation

Completed By: _____ Date: _____ Source(s): □ Pt □ Family □ MD □ H&P

Name of Pharmacy Used: _____ Primary Care Physician: _____

Medication Allergies □ NKDA □ See Allergy / Sensitivity Reaction List

Current Medications

Medication Name Include vitamins & herbal supplements	**Purpose** Reason for giving meds	**Dose** Ex: mg, units	**Route** By Mouth Unless Otherwise Indicated.	**How Often** Ex: daily, twice a day, as needed	**DC'd**	**Last Taken**	**Continue at Discharge**

Added Medications

Medication Name Include vitamins & herbal supplements	**Purpose** Reason for giving meds	**Dose** Example: mg, units	**Route** By Mouth Unless Otherwise Indicated.	**How Often** Ex: daily, twice a day, as needed	**DC'd**	**Last Taken**	**Continue at Discharge**

Medication Lists Reviewed with each Admission

ASC USE ONLY	Med list reviewed with Patient	□ Yes □ No	Date/Time	By:
	Med list reviewed with Patient	□ Yes □ No	Date/Time	By:
	Med list reviewed with Patient	□ Yes □ No	Date/Time	By:

BUCKEYE Surgery Center

Medication Allergies	Reaction
Herbal Remedies / Supplements / Non-Prescription Medications	**Reaction**
Food Allergy	**Reaction**

Latex	Reaction From
Experienced runny nose, tearing, sneezing, or itching after(Check all that apply):	❑ Dental/internal exam ❑ Blowing up balloons ❑ Contact with rubber gloves/products ❑ Use of condoms or diaphragms ❑ Eating bananas, avocados, water chestnuts or kiwi

1st Visit	**Patient Sticker**	❑ **Allergies / Reactions reviewed with patient**
2nd Visit	**Patient Sticker**	❑ **Allergies / Reactions reviewed with patient** ❑ **Additional allergies / reactions recorded since previous admission**
3rd Visit	**Patient Sticker**	❑ **Allergies / Reactions reviewed with patient** ❑ **Additional allergies / reactions recorded since previous admission**

_____ _____ _____

MD Signature Date Time

To continue home meds checked

BUCKEYE Surgery Center

Patient Tuberculosis Assessment Questionnaire

Please complete the following:

Have you ever had a positive TB skin test? Yes _____ No _____
Have you ever had a chest X-ray to check for TB? Yes _____ No _____
*If "YES", was chest X-ray Positive _____ Negative _____
Have you ever been medically treated for TB? Yes _____ No _____

Do you currently have any of the following symptoms?

Cough lasting longer than two weeks Yes _____ No _____
Unexplained fever Yes _____ No _____
Night Sweats Yes _____ No _____
Blood tinged sputum production (coughing up blood) Yes _____ No _____

If you answered YES to any of these questions, please describe symptoms/reason. When did the symptoms begin? Have you sought treatment? If yes, what treatment was done?

_____

_____

_____

_____ _____
Patient/Legally Authorized Representative Signature Date

_____ _____
Reviewed Date

Action taken: _____

_____

_____

Insurance

We will be happy to assist you in filing the insurance claim for your surgery. In order to do this, we will need copies of your insurance cards.

Medicare Patients: We are an approved Medicare facility. Therefore, we will bill Medicare according to their allowable rates. As a Medicare Part B participant, you are responsible for the annual deductible, the 20% of the charges, known as "co-insurance", and any non-covered services. A Medicare supplement insurance policy may cover these charges.

Contracted Insurances: We are contracted with many major insurance plans. If you are covered under any of these plans, we will bill your insurance under the contracted guidelines. If your coverage indicates a copay, deductible or any portion for you to pay, you will be expected to pay that amount on the day of service.

Private Insurance Patients: If we have a contract with your insurance carrier, we will file the claim for you. Since we have no control over your policy limits, filing of your insurance claim does not relieve you of responsibility for the full charges.

Self-pay Patients: If you do not have health insurance coverage, or if your insurance company will not cover your services at Buckeye Surgery Center, payment for your surgery will be expected at the time of admission, unless prior arrangements have been made with our facility.

We accept many forms of payment: check, money order, debit card, VISA, Mastercard, American Express, and Discover.

Anesthesia Billing Information

Buckeye Surgery Center has several anesthesiologists who have been credentialed and granted privileges to work at the surgery center. They are not employees or agents of Buckeye Surgery Center and they bill for their services separately from the Ambulatory Surgical Center (ASC).

It is not always possible for all anesthesiologists to be contracted with all insurance plans. However, even if not contracted with your insurance plan, the anesthesiologist have agreed to accept as payment in full the amount that would be allowed for such services if provided by anesthesiologist who have entered into a contract and are in network with your insurance plan.

If your anesthesiologist is not contracted with your insurance plan, your anesthesiologist's billing office will submit a bill for his/her charges to your insurance plan. In the event you receive a bill from your anesthesiologist or his/her billing office that does not appear to have been previously processed by your insurance plan, or if you receive a payment directly from your insurance plan for anesthesia services provided, please contact your anesthesiologist's billing office.

For ANY questions regarding anesthesia billing, please contact:

Donna at E&A Medical Billing
7878 N 16th St Ste 250, Phoenix, AZ 85020
602-308-7802

BUCKEYE Surgery Center

Advance Directive: Statement of limitation

Patients requesting "Do Not Resuscitate" in their advance directives will be requested to provide the facility with a written and notarized or witnessed copy.

This facility does not provide implementation of advanced directives; on the basis of conscience (the scheduled procedure is an elective procedure), regardless of the contents of any advance directive or instructions from a health care surrogate or attorney**.**

If an adverse event occurs at this facility, we will initiate resuscitative or other stabilizing measures and transfer patient to an acute care hospital for further evaluation.

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.

Buckeye Surgery Center requires all staff members to recognize the statutory right of a patient who is a competent adult to decide whether to receive or refuse medical treatment. The decision may be in the form of Advance Directives for Health Care Decisions ("Advance Directive").

If an adult patient is unable to make or communicate health care treatment decisions, Buckeye Surgery Center shall make a reasonable effort to locate a health care directive. Buckeye Surgery Center shall also make a reasonable effort to consult with a surrogate.

Buckeye Surgery Center will not discriminate against a patient based on the existence or non-existence of an advance directive.

An attending physician who is unwilling or unable to follow the Advance Directive of a patient shall, without delay, transfer the patient, or not hinder the transfer of the patient, to another physician who will follow the Advance Directive.

At the time of the facility admission, each patient shall be provided a written summary of Buckeye Surgery Center's policy on Advance Directives. Each adult patient shall also sign the Advance Directive Acknowledgement.

Advance Directives provided to Buckeye Surgery Center by the patient shall be placed in the patient's medical record.

Any attempt by the patient to revoke an Advance Directive shall be honored.

You can find the relevant Arizona Statutes addressing these issues as follows:

- Health Care Power of Attorney: Arizona Revised Statutes §§ 36-3221 et seq.
- Health Care Directives: Arizona Revised Statutes §§ 36-3201 et seq.
- Agents or Surrogate Decision-Makers: Arizona Revised Statutes §§ 36-3231 et seq
- Living Will: Arizona Revised Statutes §§ 36-3201 et seq AND §§ 36-3261 et seq.
- Mental Health Care Power of Attorney: Arizona Revised Statutes §§ 36-3201 et seq AND §§ 36-3281 et seq.
- Prehospital Medical Care Directives (Do Not Resuscitate): Arizona Revised Statutes § 36-3251

BUCKEYE Surgery Center

Advance Directives For Health Care Decisions Acknowledgement

Buckeye Surgery Center is required by applicable Arizona State Regulations to make you aware of you rights to be involved in decisions regarding your medical care at the time of service. Specifically, you have the right to execute an Advance Directive for Health Care Decisions ("Advance Directives") either in the form of a Living Will or a Durable Power of Attorney for Health Care. To help you better understand your rights, a summary of Buckeye Surgery Centers policy on Advance Directives is being furnished to you.

I have received the following information:

A copy of Buckeye Surgery Center's Patient Rights ……	Yes / No
Summary of Arizona State Law on Advance Directives ……..	Yes / No
Summary of Buckeye Surgery Center's policy in Advance Directives ……...	Yes / No
I have executed an Advance Directive …….	Yes / No
➢Does it contain a Do Not Resuscitate clause ..……	Yes / No

If yes, anesthesia must consult with the patient regarding DNR clause

Notes:

_____

_____

_____

_____ _____ _____

Patient Signature Date Time

_____ _____ _____

Anesthesiologist Signature Date Time

I have a Living Will / Durable Power of Attorney for Health Care. (Circle appropriate)

Copy location: (name and address)

_____

_____

_____

_____ _____ _____

Patient Signature Date Time

_____ _____ _____

Buckeye Surgery Representative Date Time

BUCKEYE Surgery Center

Notice of Direct Interest

NOTICE TO PATIENTS:

We are required as an Ambulatory Surgical Center (ASC) to notify a patient if any physician has a direct insert in the ASC. The ASC must also notify the patient that the service is available elsewhere on a competitive basis. The disclosure allows the patient to make reasoned financial decisions concerning their medical care.

In compliance with the requirements, the following physicians have direct interest in Buckeye Surgery Center:

Stephen Hwang, MD

Shamil Patel, MD

ACKNOWLEDGMENT

I have read this Notice to Patients and I understand the disclosure that it contains.

_____	_____	_____
Patient Signature	Date	Time

BUCKEYE Surgery Center

Notice of Privacy Practices (HIPAA)

Authorization for the Use or Disclosure of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The ASC has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The ASC reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the ASC does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The ASC may condition treatment upon the execution of this Consent
- The patient has been provided with a Grievance procedure

Advance Directives: Statement of Limitation

- This ASC does not provide implementation of advanced directives; on the basis of conscience (the scheduled procedure is an elective procedure), regardless of the contents of any advance directive or instructions from a health care surrogate or attorney. If an adverse event occurs at this facility, we will initiate resuscitative or other stabilizing measures and transfer patient to an acute care hospital for further evaluation. 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.

_____ _____

Signature of Patient Date

Assignment of Benefits

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plans to BUCKEYE SURGERY CENTER. I hereby authorize said assignee to release all information necessary to secure payment. I understand Dr. Stephen Hwang and Dr. Shamil Patel maintains a financial interest in BUCKEYE SURGERY CENTER.

I understand that I am financially responsible for all charges not paid by said insurance, including, but not limited to, non-covered services and cosmetic procedures.

A photocopy of this assignment is to be considered as valid as an original. This assignment will remain in effect until revoked by me in writing.

_____ _____

Signature of Patient Date

BUCKEYE Surgery Center

Patient Right And Responsibilities

Buckeye Surgery Center observes and respects a patients' rights and responsibilities without regard to race, gender, sexual orientation, marital status, national origin, religion, physical or mental disability, diagnosis, economic status, personal values, or belief system. The patient has the right to exercise his or her rights without subject to discrimination or reprisal: to voice grievance regarding treatment or care that fails to be furnished; to be fully informed about a treatment or procedure and the expected outcome before it is performed; and to the confidentiality of personal medical information. The patient has the right to personal privacy; to receive care in a safe setting and to be free of all forms of abuse and harassment to include: abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault, seclusion, and restraint. The patient is not subjected to the misappropriation of personal and private property while at the surgical center by any medical staff, personnel member, employee, volunteer, or student.

As a Patient, You Have the Right to:

To have access to the patient rights and responsibilities established by this ASC;

Be treated with respect, consideration and dignity;

The right to effective communication;

The right to be respected for your cultural and personal values, beliefs, and preferences;

To be provided appropriate, security and privacy;

The right to pain management;

The right to access, request amendment to, and obtain information on disclosures of his or her health information, in accordance with law and regulation;

The right to receive care in a safe setting;

The right to information in a manner tailored to the patient's age, language, and ability to understand;

The ASC provides interpreting and translation services;

The ASC communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that fits the patient's need;

To be free from all forms of abuse, harassment, or neglect;

To be fully informed about a treatment or procedure, agree with their care, and the expected outcome before the procedure is performed;

Have the right to be involved with all aspects of their care including refusing care and treatment an resolving problems with care decisions;

Have the right to have access to spiritual care while at the center if desired;

The ASC respects the patient's right to receive care in a safe setting;

Appropriate information regarding the absence of malpractice insurance coverage;

If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf;

If a state court has not adjudged a patient incompetent, any legal representative designated by the patient, in accordance with the state law, may exercise the patients' rights to the extent allowed by state law;

To see posted written notice of the patient rights in a place or places within the ASC likely to be noticed by patients (or their representative, if applicable) waiting for treatment. The written poster will include name, address, and telephone number of a representative of the state agency to whom the patient can report complaints, as well as the web site for the Office of the Medicare Beneficiary Ombudsman;

Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse their release, except when release is required by law;

Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or a legally authorized person;

Patients are informed of their right to change their provider if other qualified providers are available;

Patients are given the opportunity to participate in decisions involving their healthcare, treatment, or services, except when such participation is contraindicated for medical reasons;

The ASC involves the patient's family in care, treatment, or services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation;

The ASC provides the patient, or surrogate decision-maker, with the information about the outcomes of care, treatment, or services that the patient needs to participate in current and future health care decisions;

The ASC informs the patient, or surrogate decision-maker, about unanticipated outcomes of care, treatment;

Marketing or advertising regarding the competence and capabilities of the organizations is not misleading to patients.

Patients are informed about procedures for expressing suggestions, complaints, and grievances, including those required by state and federal regulations;

The patient has the right to voice grievances regarding treatment or care that is (or fails to be) furnished;

The patient has the right to exercise his or her rights without being subject to coercion, discrimination, reprisal, or interruption of care that could adversely affect the patient;

Patient rights, conduct and responsibilities;

Services available at the organization;

Provisions for after hour emergency care;

Fee for services and schedules for rates in A.R.S. 36-436.01(c);

Payment policies;

Patient's right to refuse participation in experimental research;

Advance directives, as required by state and/or federal law and regulations;

The credentials of health care professionals;

Patient Responsibilities
Prior to receiving care, patients are informed of their responsibilities. These responsibilities require the patient 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 any allergies or sensitivities;

Follow the treatment plan prescribed by his/her provider;

Provide a responsible adult to transport him/her home from the ASC and remain with him/her for twenty-four (24) hours, if required by his/her provider;

Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care;

Accept personal financial responsibility for any charges not covered by his/her insurance;

Be respectful of all the health care providers and staff, as well as other patients.

Advance Directive: Statement of Limitation
This ASC does not provide implementation of advanced directives; based on conscience (the scheduled procedure is an elective procedure), regardless of the contents of any advance directive or instructions from a health care surrogate or attorney. If an adverse event occurs at this facility, we will initiate resuscitative or other stabilizing measures and transfer patient to an acute care hospital for further evaluation. 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.

Disclosure of Ownership
To receive written information about their physician's possible ownership in the ASC. Patients are informed about physician ownership prior to their procedure.

License Inspection Report
A notice identifying the location on the premises where current license inspection reports required in A.R.S 36-425 (D);

Grievance Policy
The ASC strives to provide high quality of care and achieve patient satisfaction. Patient grievances/complaints provide a means to measure achievement of this goal and to identify a need for performance improvement. Patients shall be provided with a means to register a complaint concerning any aspect of the service/care provided by the ASC.

Grievance/Complaint: Grievances are defined as related to treatment or care that the ASC provided or allegedly failed to provide.

Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness (42 CFR 488.301).

Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 CFR 488.301).

PROCEDURE
Patient Education Regarding Reporting a Grievance: Each patient is given a brochure, prior to their surgical procedure that describes how to report a grievance/complaint. Such a complaint may be registered by telephone, in writing, by email, or in person to any member of the ASC staff.

Internal Reporting: All complaints received by ASC staff shall be forwarded to the clinical director or his/her designee immediately, at least the same day.

Response to Grievance: The response timeframe starts with the date/time of the reported grievance is received. The clinical director or his/her designee will attempt to address and resolve the concern by telephone or in person within three (3) days. If resolved the patient will be notified in writing. If the grievance is not resolved at this level, and the patient continues to have a concern, the grievance is submitted in writing to the Medical Director. The patient will be informed in writing that the grievance is being sent to the next level and the timeframe involved to process it at that level.

The Medical Director will consider the submitted grievance and may request additional information or documentation. The ASC may use additional methods to resolve a grievance, such as meeting with the patient's family. There are no restrictions on the ASC staff use of additional effective methods to handle a patient's grievance.

Resolution Reporting: The ASC will provide a written notice of its decision to the patient. The written notice will include the name of the ASC's contact person, the steps the ASC took to investigate the grievance, the results of the grievance process, and the date the process was completed.

When a patient communicates a grievance to the ASC via email, the ASC may respond to the patient via email. If the patient requests a response via email, the ASC may respond via email as long as the email response contains the name of a ASC's contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the process was completed. This email meets the requirements for a written response.

In its written response to any grievance, the ASC is not required to include statements that could be used in a legal action against the ASC, but the ASC will provide adequate information to address the specific grievance. A form letter with generic statements about grievance process steps and results is not acceptable.

To Report a Concern or File a Complaint:

Isabel Marquez, RN
23390 W. Yuma Rd. Suite 106, Buckeye AZ, 85326
Phone: 623-250-4800

Arizona State Board of Physicians
1740 W Adams Street Suite 4000, Phoenix, AZ 85007

Arizona Department of Health
150 N. 18th Avenue, Phoenix, AZ 85007
Phone: 602-542-1025

AAAHC (Accreditation Association for Ambulatory Health Care)
5250 Old Orchard Rd. Suite 200, Skokie, IL 60077
Phone: 847-853-6060, Fax: 847-853-9028
E-mail: info@aaahc.org, Website: www.aaahc.org

Office of the Medicare Beneficiary Ombudsman
Online: http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Visit the web site listed above or call 1-800-MEDICARE (1-800-633-4227) for more information, to ask questions, and to submit complaints about Medicare to the Office of the Medicare Ombudsman. TTY users should call 1-877-486-2048.