Rockledge Surgery Center, Inc.

Date

Dear

You are scheduled to see us for surgery on ______________________________ at _________
In order for us to better serve you it is important that we have the following items on or before your surgery date:

- Patient Registration Form if you are new to our practice or it has been >1 year since your last visit.
- Completed Patient History Intake form (enclosed)
- Health History Form
- All insurance information/copies
- Referral from your PCP (if you are enrolled in an HMO or POS insurance plan)
- Completed copies of the following enclosed forms must be returned to RSC
    1. Financial Matters/Ownership Disclosure Form
    2. Patient Acknowledgement Form
    3. Health History Form

If you require a referral, make certain your PCP checks Consult and Treatment under "Services Required," and Outpatient Med Surg Center under "Places of Service," or the referral will not be valid.

You will have the procedure performed in Rockledge Surgery Center, Inc. located in the offices of Dermatology & Clinical Skin Care Center at 6410 Rockledge Drive, Suite 201, Bethesda, Maryland 20817. This Nationally Accredited, Medicare-certified and State licensed surgical facility provides for high-quality outpatient surgical services.

Be advised that minors undergoing a surgical procedure must be accompanied by parent or legal guardian. If you are a legal guardian for someone undergoing a surgical procedure, please bring proof of such to validate the signing of the informed consent.

Prior to your surgery, if you have any medical questions, call and ask for Pat or Stephanie.

Thank you for choosing Rockledge Surgery Center for your surgical care.

6410 Rockledge Drive, Suite 201 * Bethesda, Maryland 20817
301-530-8300 * Fax 301-530-4638

Rockledge Surgery Center, Inc.

ACKNOWLEDGEMENTS

Patient Name: ______________________________

I hereby acknowledge I have been advised in advance of the scheduled date of my procedure regarding the following surgery center practices and policies:

1. I have received a verbal explanation and have received a written copy of the Patient Bill of Rights. Initial _____

2. I have received information regarding the facility financial policies and I was offered a copy of the Facility Financial Policy. Initial _____

3. I have received information regarding the facility Privacy and Confidentiality Policy. I was offered a written copy. Initial _____

4. **I was asked if I have Advance Directives and I was advised the surgery center does not recognize advanced directives.** I have received information regarding the surgery center's policy on advanced directives policy. I was advised I could receive a copy of the official State advanced directives form and seek legal advice to develop my own. Initial _____

5. I have been advised Roberta Palestine, M.D. has ownership interest in the surgery center. Initial _____

Signature ______________________________ Date ____________________

Witness ______________________________ Date ____________________

Rockledge Surgery Center, Inc.

Financial Matters/ Ownership Disclosure

Dear ________________________

You are scheduled for a surgical procedure at Rockledge Surgery Center (RSC). RSC surgery facilities provide the highest-quality outpatient surgical services available. RSC is a Medicare certified, State licensed, accredited surgical facility.

Your procedure at the RSC Facility will be performed by a Dermatology Center physician and there will be two (2) separate claims billed to your insurance carrier on your behalf as follows:

1. A claim from The Dermatology Center, PA for the services performed by your physician; and,

2. A claim from Rockledge Surgery Center covering the costs of the facility in connection with the procedure performed.

You will also receive separate charges from the pathology lab if used.

Additionally, there is a $100.00 No Show Fee and/or Cancellation fee if the procedure is cancelled 24 hours or less from date of the procedure.

In advance of your procedure, you will be contacted by a representative from the RSC to discuss any copayment, coinsurance or deductibles that may be due, along with any other necessary payment arrangements.

Rockledge Surgery Center participates with Medicare, Carefirst/Blue Choice, AETNA, CIGNA and United Healthcare/OneNet. If you have other coverage, your out-of-network benefits will be billed for the facility charge, however YOU will only be responsible for any in-network balance equivalents. Please contact Lisa Mowell, Surgery Center Coordinator at: 301-530-8300 for questions. You will receive prior notification by telephone about your anticipated financial responsibility. If Lisa is unavailable you may contact Stacy Neira at 301-444-0157.

Roberta Palestine, M.D. owns and operates the RSC where you are scheduled to have your surgical procedure. If you wish to discuss this ownership interest with your physician or learn about other treatment options and/or facilities, please let the RSC representative know that when they contact you, or simply call your physician at the office. Your choice of treatment options is yours and will always be respected.

If you wish to have your procedure performed with RSC, please sign below. In signing, you are also acknowledging that you have read this form, including the disclosure of ownership, and have had an opportunity to ask questions, express concerns and explore your options.

________________________________ ________________________

Signature-Patient or Legal Guardian Date

Revised 1/11/2012

Rockledge Surgery Center, Inc.

HEALTH HISTORY

Name ________________________________ Occupation ______________________

Age _____ Sex _____ Height ______ Weight______ Ethnicity/Race __________________

Name, Address, and Phone Number of Primary Care Physician

____

Medications Taken/Prescription and Non-Prescription

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Do you have Advanced Directives? Yes ___ None _____

Do you have any drug allergies? Yes ____ None _____ List _________________________

Do you have any allergies to latex? Yes ____ No ____

Reactions: Rash____ Hives____Shortness of Breath____ Other_______

Do You Smoke: Yes ____No____How Much____ How Many Years? _____

Do You Drink Alcohol: Yes____No____ How Much_________ Everyday_____

Do you have a personal history of skin cancer: Yes___ No ___ Type ___________________

Do you have a family history of skin cancer: Yes ____ No ____ Type ___________________

PLEASE CIRCLE THOSE THAT APPLY

DO YOU HAVE A HISTORY OF:

Recent Cold	Diabetes	Swollen Ankles
Hayfever	Thyroid Disease	Chronic Cough
Back Pain	Asthma	Shortness of Breath
Painful Joints	Stroke	High Blood Pressure
Pneumonia	Anemia	Paralysis
Tuberculosis	Dentures	Kidney Stones
Emphysema	Loose Teeth	Liver Disease
Bronchitis	Hearing Aid	Hepatitis
Heart Attack	Ulcer	Cirrhosis
Angina	Hiatal Hernia	Jaundice
Heart Failure	Kidney Disease	COPD
Irregular Heart Beat	Bladder Trouble	Arthritis
Pacemaker	Cancer/Tumor	Fainting/Dizziness
Epilepsy/Seizures	Sickle Cell Anemia	Prolonged Bleeding
Sexually/Blood Transmitted Disease		

Have you or any member of your immediate family had an unusual reaction to anesthesia?

____
____

Have you had surgery before? Yes____No____ If yes, please list ____________________

____

PATIENT SIGNATURE______________________________ DATE_______________

REVIEWED WITH PATIENT:

Surg. Initial _______ R.N. Initial ________ Date Reviewed w/Patient _________
Surg. Initial _______ R.N. Initial ________ Date Reviewed w/Patient _________

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 ("HIPA") 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. 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 services. An example 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 actions 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 receive an accounting of disclosures of health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer".

For more information about HIPPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0403 Toll Free: 1-866-627-7748

PATIENT BILL OF RIGHTS

Each patient treated at Rockledge Surgery Center has the right to:

- Respectful care given by competent personnel with consideration of his/her privacy concerning his/her own medical care.
- Be informed of his/her rights
- To participate in the development and implementation of his/her plan of care
- Make decisions regarding his/her care.
- Be given the name of his/her physician, the names of all other physicians directly assisting in his/her care, and the names and functions of other health care persons having direct contact with the patient.
- Have records pertaining to his/her medical care treated as confidential.
- Know what Surgery Center rules and regulations apply to his/her conduct as a patient.
- Expect emergency procedures to be implemented without unnecessary delay; in the event the need to transfer the patient to another facility is necessary, the responsible person and the facility that the patient is transferred to will be notified prior to transfer.
- Good quality care and high professional standards are continually maintained and reviewed.
  Appropriate assessment and management of pain.
- Full information in layman's terms concerning diagnosis and treatment; if it is not medically advisable to give this information to the patient, information shall be given to the responsible person on his/her behalf.
- Information on after-hour and emergency care will be provided to the patient.
- Give an informed consent to the physician prior to the start of a procedure.
- Be advised of participation in a medical care research program or donor program; the patient shall give informed consent prior to participation in such a program; a patient may also refuse to continue in a program that he/she has previously given informed consent to participate in.
- Refuse drugs or procedures and have a physician explain the medical consequences of the patient's refusal of drugs or procedure.
- To be free of restraints of any form that are not medically necessary.
- Medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability, or source of payment.
- Have access to an interpreter whenever possible upon advance request.
- Be provided with, upon request, access to all information contained in his/her medical record.
- Accurate information regarding the competence and capabilities of the organization.
- Receive information regarding methods of expressing suggestions or grievances to the organization.
- Information regarding fees for services and payment policies. Receive advance information concerning the anticipated charges for services not covered by third-party payors.
- Receive information concerning the facility's policy on charity care.
- Receive information regarding Advance Directives upon request.
- Roberta Palestine, M.D. has ownership and financial interest in Rockledge Surgery Center, Inc.

Each patient treated at Rockledge Surgery Center has the responsibility to:

- Follow instructions given by his/her surgeon, nurse and medical assistant regarding preoperative and post-operative care.
- Provide the Surgery Center staff with all information regarding third party insurance coverage.
- Fulfill financial responsibility, for all services received, as determined by the patient's insurance carrier and the Surgery Center.
- Surgery Center staff will inquire as to whether a patient has an advance directive, and discuss the impact of such directive. However, the Rockledge Surgery Center does not recognize advance directives.

Patients may register a written complaint with the Administrator of the Rockledge Surgery Center, Stuart J Carson at 301-530-8300, or in writing to 6410 Rockledge Drive, Suite 201, Bethesda, MD 20817. Additional resources for filing complaints may be registered with the Maryland Office of Health Care Quality: Program Manager, Ambulatory Care Programs, Department of Health and Mental Hygiene, Spring Grove Hospital Center, 55 Wade Avenue, Catonsville, Maryland 21228 or by telephone 800-492-6005 or with the Center for Medicare Services online: http://www.medicare.gov/ombudsman/resources.asp