SOMA SURGERY CENTER
BEVERLY HILLS

Copy of the Patient's Rights

Copy of the Patient's Responsibility

Disclosure of the surgery center owners

Notification that the surgery center does not honor Advance Directives

Person and telephone number to contact with comments or complaints

Local office of the Department of Public Health

Website of CMS Ombudsman

ATTESTATION TO THE ABOVE POLICY:

In the event the patient did not receive the above documents prior to the day of the planned procedure, and due to the inability to reschedule the patient and the resulting problems, or due to the urgent need of the planned procedure and the consequences of delaying the procedure, the attending physician may waive the Policy concerning the advance notifications listed above. A notation must be made in the patient's chart indicating this decision.

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LIST OF PATIENT RIGHTS

IN ACCORDANCE WITH HEALTH AND SAFETY CODES, THE ASC AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING LIST OF PATIENT RIGHTS:

Our Surgery Center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment, or the source of payment for his or her care.

1. Considerate and respectful care and the right to exercise his or her rights without discrimination or reprisal and be free from all forms of abuse or harassment.

2. Knowledge of the name of the physician who has primary responsibility for coordinating his or her care and the names and professional relationships of other physicians who will see the patient.

3. Receives information from his or her physician about his or her illness, his or her course of treatment and his or her prospects for recovery in easily understood terminology.

4. Receives as much information about any proposed treatment or procedure as he or she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved and knowledge of the person who will carry out the procedure or treatment.

5. Participates actively in decisions regarding his or her medical care, to the extent permitted by law, including the right to refuse treatment.

6. Receives full consideration of privacy concerning his or her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to know the reason for the presence of any individual.

7. Is given confidential treatment of all communications and records pertaining to his or her care and his or her stay in the ASC. His or her written permission shall be obtained before his or her medical records can be made available to anyone not directly concerned with his or her care.

8. Receives reasonable responses to reasonable requests he or she may make for services.

9. He or she may leave the ASC, even against the advice of his or her physicians.

10. Receives reasonable continuity of care and advance knowledge of the time and location of appointment, as well as knowledge of the physician providing the care.

11. Is advised if ASC/personal physician proposes to engage in or perform human experimentation affecting his or her care or treatment. The patient has the right to refuse to participate in any research projects.

12. Will be informed by his or her physician, or a delegate of his or her physician, of his or her continuing health care requirements following his or her discharge from the Surgery Center.

13. May choose a different physician than was assigned to that patient.

14. Is made aware that this facility does not honor Advance Directives.
    For complaints or comments about your medical care, you may contact our administrator or Medical Director at 310-673-0523 or you may then contact the: **CDPH, California Department of Public Health, Division of Health Facilities Inspection, 3400 Aerojet Avenue, El Monte, CA, 91713, or your Accreditation Organization. You may also contact the Office of the Medicare Beneficiary Ombudsman at: www.medicare.gov/Ombudsman/resources.asp**

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PATIENT RESPONSIBILITIES

As a patient in our facility, you have certain responsibilities, which include:

1. To work with your health care team and to follow all safety rules.
2. To show respect and consideration to our staff and to other patients and visitors.
3. To respect the privacy of other patients.
4. To give your health care team complete and correct information about your health.
5. To tell your doctor about any changes in your health after you leave our facility.
6. To keep, or cancel in a timely manner, your scheduled appointments for your health care.
7. To follow the directions given by your health care team after you have agreed to treatment in our facility.
8. To tell your health care team if you wish to change any of your decisions.
9. To ask for clarification if you do not understand any information or instructions given to you by your health care team.
10. **This facility does not honor Advance Directives.**

Disclosure of Physician Ownership

This surgical center is owned by: **Soma Healthcare Group**

IF YOU HAVE CONCERNS:

If you have any questions or concerns about your responsibilities, you can contact our administrator or Medical Director.

If you wish to file a complaint about your care in our facility, you may contact the following agency: CDPH, California Department of Public Health, Division of Health Facilities Inspection, 3400 Aerojet Avenue, El Monte, CA 91731 or your Accreditation Organization.. You may also contact the Office of the Medicare Beneficiary Ombudsman at the following website: www.medicare.gov/Ombudsman/resources.asp

I did read and understand all of the above information.

_____

Patient Signature Date

(Please bring this form and give it to the receptionist on the day of your appointment. We will make a copy of this for you to keep in your records.)

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NOTICE OF PRIVACY PRACTICES

We may use and disclose your medical information under special restrictions.

We may use your medical information for treatment services, payment for services.

We may use your medical information for ongoing health care operations.

We may use your medical information for appointment reminders, treatment alternatives and health related benefits and services.

We may use your information if you are hospitalized and with persons involved with your care.

We may use your medical information in disaster relief efforts or as required by law.

We may use your medical information to avert a serious threat to your health or safety.

We may use your medical information for possible tissue or organ donation.

We may use your medical information related to military service, if required by law.

We may use your medical information for Worker's Compensation benefits.

We may use your medical information as needed for public health disclosures, health oversight activities, legal proceedings, lawsuits, and law enforcement.

We may use your medical information as needed by coroners, medical examiners and funeral directors.

We may use your medical information as needed for National Security, intelligence activities and for protective services of the President.

You have the right to inspect and copy your medical information, and you may request an amendment or addendum to your medical information.

You may request an accounting of disclosures, and you may request restrictions on the disclosure of your medical information.

You have the right to request confidential communications concerning your medical information and you may request a paper copy of your medical information.

You have the right to file a complaint or receive answers about your care.

You will not be penalized for filing a complaint.

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical practice, that as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim in the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdiction limit of the small claims court against the physician, and the physician' partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitations, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses incurred by a party for such party's own benefit.Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper addition party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 333.1 and 333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

_____
Patient or Patient's Representatives Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.
I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy. **NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

By:	By:
Physician's or Duly Authorized Representative's Signature & DATE	Patient's Signature & DATE
Print or Stamp Name of Physician, Medical Group or Association Name	Print Patient's Name
By:	By:
Signature of Translator (if applicable) DATE	Patient's Representative's Signature DATE
	Print Name and Relationship to Patient

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CONSENT FOR TREATMENT

I, _____agree to the performance of _____
at the anatomical site of _____ by my physician,
_____ M.D. and others he or she may consider necessary.

I understand that during the course of the procedure describe above it may be necessary or appropriate to perform additional procedures which are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures as they may be deemed necessary or appropriate.

The risks and benefits of the procedure have been explained to me. The risks include, but are not limited to: bleeding, infections, nerve damage, prominent scar that may require further surgery and possible tumor recurrence. No guarantee or assurance of results can be made.

I understand that there are certain medical and surgical alternatives to this procedure and I have been given information regarding other medically and surgically feasible forms of care.

I permit Dr._____ to take photographs and/or videotapes of me for educational and teaching purposes during the course of my hospital, outpatient or research treatment. The photographs and information relating to my case may be published or used for any other professional purpose.

I authorize the review of my medical records by a non-staff physician (peer reviewer) in the interest of improving patient care. I also authorize all surgery center personnel not to honor any Advance Directives.

All my questions have been addressed and answered and I voluntarily give my signed authorization for this procedure.

Signature of Patient	Date and time signed
Signature of Witness	Date and time signed
Signature of Physician	Date and time signed

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ANESTHESIA CONSENT FORM

I hereby authorize and direct the anesthesiologist, (or anesthetist), _____to administer intravenous sedation, (MAC) or general anesthesia for the surgery I have consented to have performed. I understand the anesthesiologist (or anesthetist) will choose the type of anesthetic which he or she believes in their best professional judgment is the safest and most effective under the circumstances. I further understand that the type of anesthesia may be altered from that which was discussed by the anesthesiologist (or anesthetist) for the safety and well being of the patient.

I understand that although favorable results can be expected, they cannot be and are not guaranteed. There is no guarantee against poor results or complications, either expressed or implied.

It is my understanding as the patient, or that of my legal representative, that the anesthesiologist (or anesthetist) will have complete charge of the administration and maintenance of the anesthesia during the planned procedure. I acknowledge that anesthesia is an independent function apart from the surgery. Due to this fact an adverse result from a surgical procedure may not relate to the results from the anesthesia administered.

I also agree to pay all anesthesia fees for those services and understand those fees will be separate from the surgery fees.

Patient's Signature _____

Date _____

Time signed _____ a.m./p.m.

_____

Anesthetist or anesthesiologist's signature _____

Date _____

Time signed _____ a.m./p.m.

_____

Witness' Signature _____

Date _____

Time signed _____ a.m./p.m.

_____

Relationship to patient? _____

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POLICY REGARDING ADVANCE DIRECTIVES

An advance care directive, also known as living will, are instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity, and appoints a person to make such decisions on their behalf. A living will is one form of advance directive, leaving instructions for treatment. Another form authorizes a specific type of power of attorney or health care proxy, where someone is appointed by the individual to make decisions on their behalf when they are incapacitated. People may also have a combination of both.

I,_____ do not have an advance directive.

I, _____have an advance directive and will supply a copy.

I understand what an advance directive is and acknowledge that this Surgery Center does not honor Advance Directives.

For more information about advance directives and how to obtain an advance directive, please visit the sites listed: www.Partnershipforcaring.org; www.caringinfo.org/googlehealth; www.sos.ca.gov/ahcdr/forms.htm.

Every effort will be made to treat the patient who exhibits cardiac arrest or any other life threatening event. All Staff Members at the surgery center will be trained in CPR and/or ACLS and every effort will be made to revive the patient or attempt to save the patient's life.

_____ _____

Patient Signature Date

_____ _____

Witness Date

_____ _____

Physician Signature Date