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FACILITY REGISTRATION FORM

Today's Date:_____ Primary Care Doctor:_____

Referring Doctor (if any):_____

PATIENT INFORMATION

Patient's Name:_____ (Last / First / MI) Legal Name (if different):_____ (Last / First / MI)

Maiden Name:_____ DOB:_____ Age:_____ Sex:_____

Home Address:_____ P.O. Box:_____

City:_____ State:_____ ZIP Code:_____

Home Phone: (_____)_____ May we leave confidential voicemail messages at this number? ☐Y ☐N

Cell Phone: (_____)_____ May we leave confidential voicemail messages at this number? ☐Y ☐N

Email address:_____ Any restrictions on contacting you? ☐Y ☐N

Specify:_____

Marital status: ☐Single ☐Married ☐Partnered ☐Divorced ☐Separated ☐Widowed

How did you hear about us? ☐Friend/Family_____ ☐Newspaper/Magazine ☐Radio ☐TV

☐Internet ☐Other:_____

Social Security Number:_____ Spouse/Partner's SSN:_____

Driver's License #:_____ Spouse/Partner's Driver's License #:_____

Employer:_____ Spouse/Partner's Employer:_____

Work Phone: (_____)_____ Spouse/Partner's Work Phone: (_____)_____

Work Address:_____ Work Address:_____

City/State/ZIP:_____ City/State/ZIP:_____

Occupation:_____ Occupation:_____

PERSON RESPONSIBLE FOR BILL

☐Self ☐Spouse/Partner ☐Parent/Guardian ☐Other:_____

If responsible party is Parent/Guardian or other, please complete the following:

Name:_____ (Last / First / MI)

Home Address:_____ P.O. Box:_____

City:_____ State:_____ ZIP Code:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Employer:_____ Occupation:_____

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INSURANCE INFORMATION

Primary Insurance: _____

Insurance Address: _____

Insurance Phone: (_____)_____

Subscriber Name: _____

Subscriber DOB:_____

Subscriber SS#:_____

Plan Name:_____

Group #:_____

Policy #: _____

Out of Network Benefits? ☐Y ☐N

Co-Pay $_____

Patient's Relationship with Subscriber: _____

Secondary Insurance:_____

Insurance Address:_____

Insurance Phone: (_____) _____

Subscriber Name: _____

Subscriber DOB:_____

Subscriber SS#:_____

Plan Name:_____

Group #:_____

Policy #: _____

Out of Network Benefits? ☐Y ☐N

Co-Pay $ _____

Patient's Relationship with Subscriber:_____

EMERGENCY CONTACT

Name of local friend or relative (not living at same address):_____

Relationship to Patient:_____

Home Phone: (_____)_____Cell Phone: (_____)_____Work Phone: (_____)_____

The above information is true to the best of my knowledge. I authorize my insurance benefits for facility fees to be paid directly to Pearl SurgiCenter. I understand that I am financially responsible for any balance. I also authorize Pearl SurgiCenter or the insurance company to release any information required to process my claims.

Patient/Guardian Signature:_____ **Date:**_____

Printed Name: _____

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INSURANCE BILLING INFORMATION

THIS INFORMATION IS PROVIDED TO HELP YOU UNDERSTAND OUR BILLING POLICIES.

- Health insurance can be confusing. Many patients assume that their insurance company owes the doctor and the facility for services rendered. This is not the case. Insurance contracts are agreements between you, the patient, and your insurance company. As a courtesy to you, Pearl SurgiCenter will bill your insurance company. However, regardless of the insurance coverage, you are solely and fully responsible for the fees associated with your treatment.
- Please be aware that, depending on the type of surgical procedure that you are having, up to four other providers may bill your insurance as well. These may include your primary surgeon, assistant surgeon, anesthesia group, and the lab. These providers all bill separately for their services.
- Cancellations less than 72 hours prior to surgery **may be subject to a $250.00 cancellation fee**.
- Every attempt will be made to verify your coverage prior to delivering services but it is the insurance company that makes the final determination of your eligibility and benefits. You are ultimately responsible for all charges relating to your surgery.
- Please wait to receive our statement before making payment as there is usually a significant adjustment from the insurance Explanation of Benefits (EOB). If you fail to receive an EOB from your plan within 45 days of treatment, please contact your insurance plan to determine benefits, as they may not have made payment. Payment not received in 60 days may be transitioned to patient responsibility and you may be required to make other payment arrangements.

***** **VERY IMPORTANT** *****

Your insurance company may send payment directly to you for our facility fee. By signing below you acknowledge the insurance company check belongs to Pearl SurgiCenter and is not your property. You agree you must endorse the original check over to Pearl SurgiCenter and forward it to the center within 7 business days or the entire facility fee becomes immediately due and payable by you, the patient. Additionally, if you do not surrender the check, Pearl SurgiCenter has the legal right to generate a Form 1099 in your name and report the withheld funds as income to the Internal Revenue Service.

I acknowledge full financial responsibility for services rendered by Pearl SurgiCenter. I understand that I am responsible for prompt payment of any portion of charges not covered by insurance, including co-insurance, deductibles and co-pays. I understand patient balances are due and payable within 30 days of the statement date unless payment arrangements have been made. I understand that if I fail to make payment when due, this account may be referred to an outside agency for collection and the contingency fee assessed by the collection agency will be added to the principal and interest due. Additionally, I will be liable for any attorney fees that may be charged in the collection process.

_____

Patient Name

Patient Signature:_____ Date:_____

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FINANCIAL POLICY

We would like to thank you for choosing Pearl SurgiCenter (PSC) for your medical care. We are committed to providing you with the highest quality care and achieving desired outcomes through a collaborative effort with you, the patient. We ask that you read and sign our financial policy prior to any treatment.

In keeping with our philosophy of open communication and education, it is important that you understand the financial policies of the practice. It is equally important that you understand the terms of your medical coverage. Although our office staff is very knowledgeable about many of the different insurance plans, you are in the best position to understand the details and terms of your own plan. Typically you will find the insurance company's phone number on your insurance card and we encourage you to contact them with specific questions.

Insurance: We will submit a bill to your insurance carrier as a courtesy, but ultimately all balances are the responsibility of the patient. Please bring your insurance card with you at the time of your appointment. We contract with many insurance plans, but due to the sheer number of plans out there it is your responsibility to contact your insurance to verify that your provider is preferred with your plan.

Co-payments are due at the time of your appointment. You will be responsible for any co-insurance, deductible amounts, or non-covered services after we have received an explanation of benefits from your carrier. If you have an insurance that does not have a participating agreement with this practice, you will remain responsible for the balance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due, in full, upon receipt of that statement.

No Insurance: We require the facility fee to be prepaid one week prior to the procedure.

Laboratory/Pathology Services: Our office relies on the services of a laboratory for blood work analysis and for tissue biopsy interpretations. We have no relationship with the lab other than one of a referring physician. We do not bill for the lab's professional services. You will receive separate billings from their office. If you have a question regarding a bill received from the lab, please contact them directly. If they state that there is a problem with the diagnosis code on the requisition, please contact your provider's nurse (not our billing office), as the nurses handle the requisitions.

IMPORTANT POLICY NOTICE: Should you need to cancel your appointment, please provide a minimum of 72 hours notice. This helps us to schedule another patient in need of care. Pearl SurgiCenter policy requires that all patients who are either no-shows or late cancellations be charged a $250 administrative fee. Thank you for helping us ensure your fellow patients have equal access to timely, quality care.

I acknowledge full financial responsibility for services rendered by Pearl SurgiCenter (PSC). I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance including co-insurance, deductibles and co-pays. I understand payment of co-pays is expected at time of service. I also consent that the payment of authorized insurance benefits be made on my behalf directly to PSC for any medical or surgical services furnished. I understand that if I fail to make payment when due, this account may be referred to an outside agency for collection. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due and possibly attorney fees. Both collection agency fees and attorney fees will increase the balance I owe.

_____

Patient Name

Patient Signature: _____ Date: _____

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CONDITIONS OF ADMISSION

Thank you for entrusting Pearl SurgiCenter with your care. We will do everything within our power to make your experience as pleasant as possible. Please carefully read the following important conditions of admission for our facility. We encourage you to ask questions if there is anything you don't understand.

1. **FINANCIAL AGREEMENT**
   The undersigned agrees, whether he/she signs as an agent or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the center in accordance with the regular rates and terms of the center. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts shall bear interest at the legal rate.

2. **HEALTH CARE SERVICE PLANS**
   This center maintains a list of the health care service plans with which it has contracted. A list of such plans is available upon request from the financial office. The center has no contract, express, or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full cost of services rendered to him/her by the center if he/she belongs to a plan that does not appear on the above-mentioned list.

3. **ASSIGNMENT OF INSURANCE BENEFITS**
   The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the center, or any insurance benefits or Unemployment Compensation Disability otherwise payable to the undersigned for this hospitalization at a rate not to exceed the center's regular charges. It is agreed that payment to the center pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

4. **RELEASE OF INFORMATION**
   To the extent necessary to determine liability for payment and to obtain reimbursement, the center may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the center's charge, including but not limited to, insurance companies, health care service plans or worker's compensation carriers.

5. **MEDICAL AND SURGICAL CONSENT**
   The patient is under the care and supervision of his/her attending physician and it is the responsibility of the center and its nursing staff to carry out the instructions of such physician; the undersigned recognizes that all physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, and the like, are independent contractors and are not employees or agents of the center. The undersigned consents to X-ray examination, laboratory procedures, anesthesia, medical, or surgical treatment or center services rendered the patient under the general and special instructions of the physician.

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6. NURSING CARE

This center provides only general duty nursing care unless upon orders of the patient's physician the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the patient or his/her legal representative. The center shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

7. PERSONAL VALUABLES

It is understood and agreed that the center advises patients to leave all valuables at home, and that the center shall not be liable for the loss or damage to any personal property.

The undersigned certifies that he/she has read the foregoing, receiving a copy thereof, and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept its terms.

- **Patient/Parent/Guardian Signature:** _____ Date: _____

  Printed Name: _____ Time: _____

  Relationship if other than patient: _____

- **Witness Signature:** _____ Date: _____

  Printed Name: _____

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OHPR REQUIREMENTS

Print Name: _____ Date: _____

The 2003 Oregon Legislative Assembly passed House Bill 3653, creating the Oregon Health Policy Commission (OHPC) to develop and oversee health policy and planning for the state. The Commission identifies and analyzes significant health care issues affecting the state and makes policy recommendations to the Governor, the Oregon State Legislature and the State Office for Oregon Health Policy and Research (OHPR). Additionally, the Commission partners with health care experts and stakeholders around the state to develop projects which ensure access to essential health care and support services, increase health care quality and improve health outcomes for individuals and society, control costs, and encourage healthy lifestyles. Per correspondence from OHPR to all Oregon ASCs, in a letter dated 07/28/07, new reporting requirements are being instituted beginning with 2008 discharge data.

In addition to the information already obtained, the state also requires the patient to self-report their race and ethnicity. Please choose one each from the following catagories:

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Patient Refused
- ☐ Unknown
- ☐ Other

Ethnicity

- ☐ Hispanic
- ☐ Non Hispanic or Latino Ethnicity
- ☐ Patient Refused
- ☐ Unknown
- ☐ Other

Please understand that the Pearl Women's Center regrets the need to ask for this information and will use it only in compliance in reporting to OHPC to avoid the penalty fine. Thank you for your help.

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NOTICE OF PRIVACY PRACTICES

The new privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) require that medical groups provide patients with a notice that describes how protected health information may be used and disclosed, and that explains patients' rights and the medical group's duties.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment: We are permitted to use your health care information as necessary to provide you with medical treatment and services. We may disclose information about you to physicians, nurses, technicians, medical students or others who are involved in taking care of you. For example, our physicians may share information about your diabetes with an orthopedic specialist they are referring you to so that they will be aware that your healing process may take a bit longer.

Payment: We are permitted to use and disclose your health care information in order to bill and receive payment from you, or your insurance company for the services you receive from us. As an example, we will share information about your office visit with your insurance company so that they will reimburse us for the care you received. We will also share information with your insurance company about your condition and the treatment you are going to receive in order to determine if it will be pre-approved for payment by your insurance company.

Health Care Operations: We are permitted to use your health care information for our business operations. For example, our physicians may use your information to determine the quality of care you have received, and whether any improvements are needed in our systems. We may also disclose your information to another health care provider or health plan if they have a relationship with you and require the information for their own business operations.

Our practice is permitted or required to use or disclose confidential information without your written authorization in the following cases:

a) Uses and disclosures for public health activities; such as reporting disease, injury and vital events such as births and deaths, reporting about victims of abuse, neglect or domestic violence; and reporting reactions to medications and problem products.

b) Disclosures for health oversight activities for activities authorized by law including audits, investigations, inspections and licensure.

c) Disclosures for judicial and administrative proceedings where required by the court or an administrative order if you are involved in a lawsuit or a dispute.

d) Disclosures for law enforcement purposes where required by court order, warrant, criminal subpoena or other lawful purposes.

e) Uses and disclosures about decedents where required by state and federal law.

f) Uses and disclosures for cadaveric organ, eye or tissue donation purposes, where required by law, or your personal preferences that you have recorded in your chart.

g) Disclosures to avert a serious threat to health or safety, where required by state or federal regulations.

h) Uses and disclosures for specialized government functions, including monitoring US health care systems, government programs and compliance with civil rights laws.

Other uses and disclosures will be made only with your written authorization and that you may revoke such authorization at any time.

SEPARATE STATEMENTS FOR CERTAIN USES OR DISCLOSURES

The practice may contact you to provide appointment reminders or information about treatment alternatives or other heath related benefits and services that may be of interest to you.

The practice may contact you to request your participation in marketing or fundraising activities for the practice.

INDIVIDUAL RIGHTS

As a part of the new regulations, you have several individual rights with respect to protected health information:

1. You have the right to request restrictions on certain uses and disclosures, although the practice is not required to agree to a requested restriction;
2. You have the right to receive confidential communications;
3. You have the right to inspect and copy protected health information, provided your physician has not deemed that inspection to be a danger to your health or the health of others;
4. You have the right to requrest that we amend protected health information, should you find it to be incomplete or in error;
5. You have the right to receive an accounting of disclosures of protected health information; and
6. You have the right to obtain a paper copy of this notice from the practice upon request, even if you have previously agreed to receive this notice electronically.

MEDICAL PRACTICE'S DUTIES

1. Our practice is required by law to maintain the privacy of confidential information and to provide individuals with notice of its legal duties and privacy practices with respect to such information;
2. Our practice is required to abide by the terms of the notice currently in effect; and
3. Our practice reserves the right to change the terms of this notice and to make the new notice provisions effective for all confidential information that we maintain. Should we decide to change the terms of our notice, we will send the revised notice to you either in electronic format, or via paper, depending upon your previously stated preference.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the practice (see contact information below) and/or to the Secretary of the DHHS by writing to:

Secretary of the US Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Please note that we will not retaliate against you in any way for filing complaints. Should you have any questions or complaints, please direct them by mail to:

Administrator
Pearl SurgiCenter
120 NW 14th Avenue, STE 200
Portland, OR 97209 | 503.771.1883

EFFECTIVE DATE

These regulations became effective on April 14, 2003

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ACKNOWLEDGMENT OF RECEIPT OF
"NOTICE OF PRIVACY PRACTICES" AND "PATIENT RIGHTS"

I acknowledge that I have received copies of "Notice of Privacy Practices" and "Patient Rights".

_____ _____
Patient Signature (or Representative and relationship to patient) Date

DOCUMENTATION OF GOOD FAITH EFFORTS
(To obtain patient's acknowledgment of receipt "Notice of Privacy Practices" and "Patient Rights")

Patient Name: _____

The patient presented to the center on _____ and was provided with a copy of "Notice of Privacy Practices" and a copy of "Patient Rights". A good faith effort was made to obtain written acknowledgment of receipt of the documents; however, such acknowledgment was not obtained because:

_____ Patient refused to sign

_____ The patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity

_____ Patient was unable to sign or initial because: _____

_____

_____ Other reason (describe): _____

_____

_____

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PATIENT RIGHTS

Patients have the right to:

- Treatment without discrimination of race, sex, age, national origin or cultural, economic, educational, or religious background, or the source of payment for care.
- Considerate, dignified and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment exploitation and/or reprisal.
- The knowledge of the name of the surgeon who has primary responsibility for coordination of care and the names and professional relationships of other practitioners who will see them. All healthcare professionals practicing at the facility have had their credentials verified and have been approved to practice at the facility by the Governing Board.
- Receive information from their surgeon about their illness, course of treatment, and prospects for recovery in terms that they can understand. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Receive the necessary information about any proposed treatment or procedure in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of all the procedure(s) or treatment(s), the medically significant risk(s) involved in the treatment, expected outcome, an alternate course of treatment or non-treatment, and the risk(s) involved in each, including the name of the person who would carry out the treatment(s) or procedure(s).
- Participate actively in making informed decisions regarding their medical care. To the extent it is permitted by law, this includes the right to refuse treatment.
- Full consideration of appropriate privacy concerning their medical care program. Case discussion, consultation, examination and treatment are confidential and shall be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
- Confidential treatment of all communications and records pertaining to their care. Written permission shall be obtained before medical records are made available to anyone not concerned with the patient's care.
- Reasonable responses to any reasonable request made for services.
- Be fully informed of the scope of services available at the facility, provisions for after-hours and emergency care and related fees for services rendered
- Reasonable continuity of care and to know, in advance, the time and location of appointment(s), as well as the practitioner providing the care.
- Be advised if the surgeon proposes to engage in, or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such research projects.

- Be informed by the surgeon, or designee, of continuing healthcare requirements.
- Examine and receive an explanation of the bill and payment policies regardless of the source of payment.
- Have all patients' rights explained to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.
- Know that the facility does not honor advance directives; however, any advance directive will be noted in the patient medical record and will be communicated to other medical facilities, if a transfer is needed.
- Be informed of their right to change primary physicians if other qualified physicians are available.
- Be provided appropriate information regarding malpractice insurance coverage.
- Know that the following physician has financial interest and ownership in Pearl SurgiCenter;

  Richard Rosenfield, MD

- Report any comments or voice any grievances regarding treatment or care that is (or fails to be) furnished without being subjected to discrimination or reprisal and receive timely, fair follow-up on your comments. Grievances or complaints can be reported to:

  Administrator

  Pearl SurgiCenter
  120 NW 14th Ave Suite 200 | Portland, OR 97209
  503.771.1883

  Oregon Department of Human Services

  Complaint Department | Public Health Division
  800 NE Oregon St. Suite 305 | Portland, OR 97232
  971.673.0540

  Office of the Medicare Beneficiary Ombudsman

  1.800.MEDICARE (1.800.633.4227)
  https://www.cms.hhs.gov/center/ombudsman.asp

If a patient is adjudged incompetent under applicable state laws by a court or 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 or surrogate designated by the patient in accordance with state laws may exercise the patient's rights to the extent allowed by state law.

Medicare beneficiaries may receive information regarding their options under Medicare and their rights and protection by visiting the website for the Office of the Medicare Beneficiary Ombudsman: https://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

ADVANCED DIRECTIVE NOTIFICATION

In the State of Oregon, all patients have the right to participate in their own health care decisions and to make 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.

Pearl SurgiCenter respects and upholds those rights; however it is our policy to not honor Advance Directives. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney. Official State forms are available at our facility if you wish to complete an Advance Directive.

PATIENT RESPONSIBILITIES

Patients are responsible for:

- Providing accurate and complete information concerning their health including present complaints, past illnesses, hospitalizations, medications, over-the-counter products and dietary supplements, any allergies or sensitivities and other matters relating to their health.
- Reporting perceived risks in their care and unexpected changes in their condition to the responsible practitioner.
- Asking questions about their condition, treatments, procedures, clinical laboratory and other diagnostic test results.
- Asking questions when they do not understand what they have been told about their care or what they are expected to do.
- Immediately reporting any concerns or errors they may observe.
- Following the treatment plan established by the physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- Keeping appointments and for notifying the hospital or physician when they are unable to do so.
- Their actions should they refuse treatment or not follow the physician's orders.
- Assuring that their financial obligations for their care are fulfilled as promptly as possible.
- Following center policies and procedures.
- Being considerate of the rights of other patients and center personnel.
- Being respectful of their personal property and that of other persons in the center.
- Providing a responsible adult to transport him/her home from the facility and remaining with him/her for 24 hours

In the event of patient non-compliance Pearl SurgiCenter has the right to terminate or postpone treatment until the situation is rectified.