5950 South Durango Dr. Suite 101

Las Vegas, Nevada 89113

702-462-9820

Please send this packet via email to the surgery center

amy.story@silverstateasc.com

Please CC: ro.johnson@silverstateasc.com

ASSIGNMENT OF RIGHTS AND BENEFITS FORM

I __________________________hereby authorize my insurance company (including private insurance and any other health/medical plan), my employer, my healthcare contractor, agents, assignees, and/or any other organization obligated to cover the cost of my healthcare benefits (collectively, "Insurance Company") to direct any and all payments for any and all professional and medical services ("Medical Services") that I receive pursuant to my plan benefits directly to Provider(s) and/or Facility(ies) providing said Medical Services, or their designated associates or assignee(s) (collectively "Provider"). I hereby authorize Provider to obtain, including electronically or via email, on my behalf, the insurance plan, insurance, and benefits policy booklet, and all other policy information from Insurance Company. I also provide express consent and give full rights to Provider to initiate and process any appeal on my behalf to Insurance for any reason

I hereby fully assign to Provider all payments for Medical Services that are due to me and/or that I received pursuant to my benefits plan from any Insurance Company. I hereby authorize and direct my Insurance Company to issue payment check(s) for authorized Medical Services directly to:

Silver State Surgery Center West
5950 South Durango Drive Suite 101
Las Vegas, NV 89113

for Medical Services which are otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered by Provider. I understand that as a courtesy to me, the Provider will file a claim with my insurance company on my behalf. I understand that my Insurance Company may disallow certain diagnoses or services as medically uncovered, medically unnecessary, cosmetic, or excluded. I agree to be financially responsible for, and hereby affirmatively agree to pay, in a timely manner, charges for all services received and denied or otherwise not covered by my Insurance Company.

If my current policy prohibits direct payment to the Provider, I hereby also instruct and direct any payor to provide payment in my name and **mail it to the above address of Provider** for the Medical Services expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered.

Additionally, in the event payment(s) are mailed directly to me by the Insurance Company, I hereby represent and warrant that I agree to endorse such payment and write "Payable to" on the back of the check and send the check along with an Explanation of Benefits (EOB) attached to the check to Provider at the above address immediately upon receipt. Alternatively, I agree to immediately deposit the check and forward a personal or cashier's check for the full amount to Provider at the above address.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the Provider, Insurance Company, or another medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original will be kept on file by the Provider.

If it is necessary to file a formal collection action, I agree to pay all costs incurred in the collection of the outstanding fees.

Initials of Insured or Responsible Person/Guardian/Patient: ______________

I agree that I am responsible for annual deductibles, co-pays and charges not covered by my Insurance Company(s). Physician, Laboratory and Pathology services that are billed separately from the Facility.

It is my responsibility to notify the Provider of any changes in my health care coverage. Exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Provider and/or my Insurance Company if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for Medical Services received.

I hereby acknowledge that this is a direct assignment of my rights and benefits under this policy and that:

- A photocopy of this assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize Silver State Surgery Center West to deposit checks made in my name.
- I understand that I am financially responsible for all charges whether or not they are paid by insurance.

In addition to the assignment of all rights, medical benefits and/or insurance reimbursement above, I also assign and/or convey to Silver State Surgery Center West *any* state or federal legal action, administrative claim or action, right to an administrative appeal arising under any group health plan, employee benefits plans, health insurance or insurance concerning medical expenses incurred as a result of the services, treatments, therapies, testing and/or medications I received. This constitutes an irrevocable express and knowing assignment of any ERISA breach of fiduciary duty claims, ERISA claims for reimbursement, or equitable claims under ERISA.

This voluntary assignment is valid for all lawsuits, under state or federal law directed against commercial health plans, health maintenance organizations, PPACA (Patient Protection and Affordable Care Act), ERISA, Medicare or Medicaid.

I represent and warrant that I have read and understand this Assignment of Rights and Benefits Form and agree to abide by and comply with all provisions contained herein.

Thank you for choosing Silver State Surgery Center for your surgical procedure.

Although you have executed an assignment of benefits that your insurance company should honor, they may send **you** a check.

If you receive a check, you will need to endorse the back of the check and write Payable to: **Silver State Surgery Center**

Then send the check along with the **E**xplanation **o**f **B**enefits (EOB) that was attached to the check to… **Silver State Surgery Center**

____ ________________

Responsible Person/Guardian/Patient Signature **Date:**

Patient Health History Questionnaire:

Please answer the following questions Yes or No

Do you now have, or have you ever had or been treated for, any of the following conditions, illnesses, diseases or symptoms?

CARDIOVASCULAR	Yes	No	Date Year
1. High Blood Pressure / Hypertension	___	___	____
2. Heart Attack / Myocardial Infarction			
3. Angina / Chest Pain	___	___	____
4. Heart Bypass / Stent / Angioplasty	___	___	____

NEUROLOGICAL	YES	No	Date Year
5. Stroke / CVA	___	___	____
6. Seizures / Convulsions	___	___	____
7. Depression	___	___	____
8. Anxiety	___	___	____

RESPIRATORY	Yes	No	Date Year
9. Abnormal Chest X-ray / TB	___	___	____
10. Asthma / Reactive Airway Disease	___	___	____
11. Bronchitis: Acute Chronic	___	___	____
12. Emphysema / COPD	___	___	____
13. Recent Cold or Respiratory Infection (During the Last 4 Weeks)	___	___	____
14. Shortness of Breath at Rest	___	___	____
15. Shortness of Breath with Exertion	___	___	____

Comments:

	Yes	No	Date Year
16. Cough (With or Without Sputum Production)	___	___	____
17. Sleep Apnea	___	___	____
18. C-pap machine setting	___	___	____
19. Do you smoke?	___	___	____
ENDOCRINE			
20. Diabetes Type I Type II	___	___	____
21. Thyroid Disease or Surgery	___	___	____

Comments:

HEMATOLOGIC / ONCOLOGIC	Yes	No	Date Year
22. Bleeding Easily (Gums, Nose)	___	___	____
23. Easy Bruising	___	___	____
24. Anemia (Low Blood or Low Blood Count)	___	___	____
25. HIV positive	___	___	____
26. Blood Clots: Legs Lungs	___	___	____
27. Hepatitis of any kind	___	___	____
28. Chemo / Radiation Therapy	___	___	____

Comments:

MUSCULOSKELETAL	Yes	No	Date Year
29. Arthritis: Osteo Rheumatoid	___	___	
30. Metal Implants of any kind	___	___	____
31. Neck / Back Surgery or Fusion(s)	___	___	____
32. Paresthesia's / Weaknesses	___	___	____
33. Diseases of the Muscles	___	___	____

Comments:

GASTROINTESTINAL	Yes	No	Date Year
34. Alcoholic Liver Disease	___	___	____
35. Acid Reflux - GERD - Heartburn	___	___	____
36. Difficulty Swallowing	___	___	____

Comments:

URINARY / REPRODUCTIVE	Yes	No	Date Year
37. Urinary / Kidney disease	___	___	____
38. Hemodialysis	___	___	____
39. Kidney Stones	___	___	____

Last Menstrual Cycle ____________

☐ Hysterectomy ☐ Menopause

Have you or any of your family had any unusual reaction to Anesthesia? Y__ N___

LIFE STYLE	Yes	No
40. Cigarette smoking	___	___
41. Vaping / Hookah / E-Cigarettes	___	___
42. Alcohol	___	___
43. Recreational drugs	___	___

Comments:

Please list ALL ALLERGIES. (Drugs and Foods):
Of *special importance* are Egg, Nuts, Latex, Soy, and Sulfite Preservative allergies – list reaction

1.

2.

3.

4.

Surgical History:

PATIENT RIGHTS/RESPONSIBILITIES

PURPOSE:
To recognize the basic human rights of patients. Each patient admitted to the center is informed of his or her rights as a patient in accordance with the provisions of NRS 449.730. The patient is provided with a personal copy of these right and signs that they have received a copy and understands their rights as a patient.

POLICY:
SILVER STATE SURGERY CENTER WEST recognizes the following patients' rights:

1. Exercise these rights without regard to sex, cultural, economic, educational, religious background, or the source of payment for care.
2. Patients of SILVER STATE SURGERY CENTER WEST are treated with respect, consideration, and dignity. The patient has the right to be free from all forms of abuse or harassment. SILVER STATE SURGERY CENTER WEST complies with the rules for the privacy and security of individually identifiable health information.
3. Patients are provided the appropriate privacy. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly, including the right of the patient to have auditory privacy for any discussion of his/her medical treatment SILVER STATE SURGERY CENTER WEST
4. The patient must be informed, at the time of their admission, of the services available and the estimated cost of those services. If a patient is unable to understand his or her rights, they must be explained to his guardian, next of kin or the agency financially responsible for his or her care.
5. The patient has the right to be advised as to the reason for the presence of any individual involved with his/her patient care.
6. Knowledge of the name of the physician who has primary responsibility for coordination of the care at SILVER STATE SURGERY CENTER WEST, as well as the names and professional relationships of other physicians and non-physicians who will be involved with the patient care.
7. Except when required by law, patient disclosures and records are treated confidentially, and written permission shall be obtained from the patient before the medical records can be made available to anyone not directly concerned with the care.
8. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, prognosis and prospect for recovery in terms that the patient 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.
9. Patients are given the opportunity to participate in decisions involving their healthcare at SILVER STATE SURGERY CENTER WEST, except when such participation is contraindicated for medical reasons.
10. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. This information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person(s) who will carry out the procedure or treatment.
11. Information is available to patients and staff concerning:
    a. Patient rights, including those specified above
    b. Patient conduct and responsibilities
    c. Services available at the organization
    d. Provisions for after-hours and emergency care
    e. Fees for services
    f. Payment policies
    g. Patient's right to refuse to participate in experimental research
    h. Methods for expressing grievances and complaints.
    i. Advance directives, if so requested by the patient
    j. Credentialing of healthcare professionals.
    k. Absence of Malpractice Coverage
12. Patients are informed of their right to change primary or specialty physicians if other qualified physicians are available.
13. Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.
14. Patients are provided with appropriate information regarding the absence of malpractice insurance coverage.
15. Patients will receive information in a format that they can readily understand. When necessary, an interpreter will be used.
16. Reasonable responses to any reasonable requests made for services. If a patient is adjudged incompetent under applicable state laws, the rights of 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 may exercise the patient's rights to the extent allowed by state law.

17. Patients may leave SILVER STATE SURGERY CENTER WEST, even against the advice of Physicians, with a release.

18. Reasonable continuity of care and to know in advance the time and location of appointment, as well as the identity of persons providing the care.

19. Be informed of continuing healthcare requirements following discharge from SILVER STATE SURGERY CENTER WEST.

20. Patients have the right to have their pain assessed and treated promptly, effectively, and for as long as the pain persists. SILVER STATE SURGERY CENTER WEST shall ensure that pain assessment is performed in a consistent manner that is appropriate to the patient.

21. Have all "Patients' Rights" apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

22. The patient has the right to the following:

    a. Be free from any act of discrimination or reprisal and all alleged violations/grievances relating to, mistreatment, neglect, verbal, mental, sexual or physical abuse, must and will be fully documented.

    b. Exercise of rights and respect for property and person.

23. The patient has the right to voice grievances regarding treatment or care. SILVER STATE SURGERY CENTER WEST shall ensure that all patients are free from abuse or harassment. Any patient having a grievance or complaint regarding treatment or care that is (or fails to be) furnished may address the issue with the following accrediting agency:

Silver State Surgery Center West LLC recognizes the following patients' responsibilities:

1. Patients have the responsibility to provide accurate and complete information about current and past illnesses, medications, supplements, over the counter products, allergies or sensitivities and other matters pertaining to their health.
2. Patients have the responsibility to follow the treatment plan recommended by their practitioner or express concerns regarding their ability to comply.
3. Patients are responsible for their actions if they refuse treatment or do not follow the practitioner's instructions.
4. The patient must be respectful of all health care professionals, staff, and other patients in the facility.
5. Patients have the responsibility to arrive as scheduled for appointments and to <u>cancel in advance appointments they cannot keep.</u>
6. Patients have the responsibility to become informed of the scope of basic services offered, the costs, and the necessity for medical insurance and to actively seek clarification of any aspect of services and programs (including cost) that is not understood.
7. The patient must accept personal responsibility for any charges not covered by insurance.
8. Patients have the responsibility to ask for and establish payment plans individualized to the patient's needs. Payment plans will be based on the amount owed, and time needed to pay it back.
9. Patients have the responsibility to provide a responsible adult to transport him/her home from the facility and remain with him/her for twenty-four (24) hours, if required by his/her provider.
10. Patients have the responsibility to inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

A copy of the patient's rights are posted in the waiting area and patient changing area.

AAAHC
5250 Old Orchard Road, Ste 200
Skokie, IL 60077
Phone: 847-853-6060
Fax: 847-853-9028

Nevada State Health Division
Bureau of Healthcare Quality and Compliance
4150 Technology Way
Carson City, NV 89706-2009

U.S. Centers for Medicare & Medicaid Services.
7500 Security Boulevard, Baltimore, MD 21244
https://www.cms.gov/Center/Special-Topic/Ombudsman/Medicare-Beneficiary-Ombudsman-Home

The Bureau also has an agreement with the federal Centers for Medicare and Medicaid Services (CMS) to certify medical facilities and providers and skilled nursing facilities in the Medicare and Medicaid reimbursement programs. Surveys (inspections) are conducted in accordance with applicable regulations (Code of Federal Regulations, Title 42), based on the type of facility, and following specific time frames and procedures. **The Bureau also conducts complaint investigations for <u>all licensed</u> and/or certified facilities.**

Silver State Surgery Center is a licensed facility by Nevada State Health Division.

Patient Home Medication List *

(List all prescriptions and over the counter, herbals, vitamins and birth control or patch)

ALLERGIES: ☐ **NKA** ____

ABNORMAL REACTIONS: ____

Home Medication Name	Dose	Frequency (How often?)	Reason for Taking	Route (Oral, Injection, inhaler)	Last taken (date/time)	Date to Resume meds

New Prescriptions	Dose	Frequency (How often?)	Reason for Taking	Last Taken *(time if applicable)*	Instructions	Next Dose @ *(after discharge)*

My signature below confirms this is an accurate, complete and current list of my medications.

Patient Signature: ______________________________ **Pre-Op Nurse Signature:** ______________________________

Physician Signature: ______________________________

Copy given to patient upon discharge by PACU Nurse (Signature): ______________________________