KEARNEY EYE SURGICAL CENTER

PATIENT RIGHTS & RESPONSIBILITIES, FINANCIAL DISCLOSURE,
ADVANCED DIRECTIVE, GRIEVANCE PROCEDURE, PRIVACY PRACTICES

Patient Rights & Responsibilities Notice

I have received and understand the Patient Rights and Responsibilities.

____ Patient Received Copy ____ Patient Refused Copy

Financial Disclosure

I understand that Dr. Clinch, MD is the sole owner of Kearney Eye Surgical Center. I understand that I may choose to have my procedure in a facility of my choice for health related services. I understand that I will receive a separate bill/financial statement, for financial services provided in this facility. I understand that Kearney Eye Surgical Center and Kearney Eye Institute are two separate entities.

Advanced Directives

Because the scope of Kearney Eye Surgical Center is limited to elective outpatient surgical procedures, it is the policy of this facility, that any life-threatening situation that arises will be immediately treated with life-sustaining measures. Concurrently, the emergency medical system (EMS) will be activated for emergency patient transport to a hospital facility. The patients right and need to be an active participant in the decision making process regarding their care is recognized and respected. Acknowledgement of this policy does not revoke or invalidate any current health care directive or health care power of attorney.

____ Yes, I have an advanced directive/living will *and* have provided a copy to KESC.
____ No, I do not have an advanced directive/living will and/or power of attorney.
____ I would like additional information on advance health care directives.

Grievance Procedure

I understand that if I have a concern regarding any aspect of the services/care provided by the facility, I can file a grievance with the facility by contacting the Clinical Director, completing the written survey provided to me, and/or file a complaint through the DHHS Licensure Unit.

Notice of Privacy Practices

I agree that Kearney Eye Surgical Center has provided information concerning how they may disclose my protected health information (PHI). In compliance with HIPAA Privacy Provisions, and has provided a written Notice of Privacy practices in a language and manner that is understood. ____ Patient Received Copy ____ Patient Refused Copy

This includes appropriate release of and disclosure of my medical records in compliance with Privacy Provision to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me.

____ I do not object to uses and disclosures of my healthcare information
____ I request the following restrictions on uses and disclosures of my healthcare information:

I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree as listed below:

____ Contact me by the phone number I have provided.
____ KESC may leave a message on my voicemail/answering machine.
____ KESC may provide this information to others: as documented in computer system.

By signing this document, I acknowledge that I have received this information prior to my surgery.

_____ _____

Patient or Representative Signature Date

_____

Witness Signature with Title

patient label