KEARNEY EYE SURGICAL CENTER

NOTIFICATION AND ACKNOWLEDGEMENT OF PATIENT RIGHTS, FINANCIAL DISCLOSURE, ADVANCE DIRECTIVE, PRIVACY PRACTICES

Notice of Rights

Kearney Eye Surgical Center has established the Patient's Bill of Rights which is provided verbally and in writing in a language and manner the patient or patient's representative understands prior to or on the date of the procedure.

Kearney Eye Surgical Center has the expectation that observance of these rights will contribute to more effective patient care and a greater satisfaction for physicians, patients and the facility.

Financial Disclosure

Kearney Eye Surgical Center has shared ownership by Dr Blakely, MD and Dr Clinch, MD. The patient has the right to choose the facility of his/her choice for health related services.

Advance Directives

It is the policy of Kearney Eye Surgical Center, regardless of any advance directives or medical living wills, or other instructions from a health care surrogate or power of attorney, that if an unexpected medical emergency were to occur during treatment at this facility, it will be managed with resuscitative or other stabilizing measures followed by emergency transfer to Good Samaritan Hospital. Good Samaritan Hospital will implement further treatment or withdrawal of treatment measure already begun in accordance with patient wishes, advance directive or health care power of attorney. Acknowledgement of this policy does not revoke or invalidate any current health care directive or health care power of attorney.

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

Notice of Privacy Practices

Kearney Eye Surgical Center has provided information concerning how they may disclose my protected health information (PHI) and has provided a written Notice of Privacy practices in a language and manner that is understood.

KESC may use the following methods of communication regarding my personal health, medical treatment and payment information. I acknowledge that I am responsible for updating this information as necessary.

___ Contact my by phone: ___home ___ cell ___work ___other: _____

___ KESC may leave a message on my voice mail/answering machine

___ KESC may speak to _____

By signing this document, I acknowledge that I have received this information prior to my surgery, that I have read and understand the information on financial disclosure, notice of privacy practices and how KESC may disclose my (PHI), patient rights and advance directives and agree to the policies of Kearney Eye Surgical Center. If I have indicated I would like additional information, I acknowledge receipt of that information.

_____ _____
Patient or Representative Signature Date

_____ _____
Witness Signature Date

Patient label