Tarzana Outpatient Surgical Institute
5620 Wilbur Ave. Suite 305 Tarzana, CA 91356
818-578-5125

NOTICE OF PRIVACY PRACTICES

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USEDAND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** This notice is provided in two layers: This top layer briefly summarizes how we handle your health information, and the attached bottom layer provides further details of our privacy policies and procedures.
2. **How We May Use The Disclose Your Health Information**. We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you referred. Information may be shared by paper, mail, electronic mail, fax or other methods. We may use or disclose your health information without your authorization to disclose information before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future uses and disclosures.
3. **Your Rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information is incorrect or information is missing, you have the right to request that we correct the existing information or add missing information.
4. **Our Legal Duty.** We are required by law to protect the privacy of your health information provide this notice about your privacy practices. Follow the privacy practices that are described in this notice and seek your acknowledgement of receipt of this notice. For more information about our privacy policies, contact the person listed below.
5. **Privacy Complains.** If you are concerned that we have violated your privacy rights our privacy policies or if you disagree with a decision we made about access to your health information you may contact the person listed below. You may also send a written complaint to the U.S Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:
Privacy Officer
5620 Wilbur Ave, Suite #305
Tarzana, CA 91356
(818)578-5125

Acknowledgment of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date. Below to acknowledge that you have received both layers of this Notice of Privacy Practices

Signature_____ Printed Name_____

Witness_____ Date_____

BRAND TARZANA SURGICAL INSTITUTE

PATIENT RIGHTS & RESPONSIBILITIES

You Have The Right:

- **To be treated with respect, consideration, and dignity, without discrimination on the basis of race, color, sex, religion, or national origin.**
- **To know the policy on rights and responsibilities you have as a patient.**
- **To participate in decisions involving your healthcare; to be assisted in the development of advance directives, and to know and take responsibility for the consequences of refusing treatment or not complying with therapy.**
- **To receive services in a safe and clean environment.**
- **To privacy and confidentiality, and to approve or refuse the release of your medical records, except when release is required by law**
- **To receive information concerning your diagnosis, treatments, and prognosis: and to accept or refuse treatment after full information is given.**
- **To know what provisions are available for after hours and emergency coverage; and to have access to an interpreter as needed in order to understand explanations.**
- **To know the fees for services provided and the policies regarding the payment of fees.**
- **To be free from abuse or neglect; to access protective services**
- **To be referred to specialists and other professionals when needed, and to change physicians if you are not satisfied and if other qualified physicians are available.**
- **To voice a compliment or complaint by calling (818) 578-5125**

You Have The Responsibility:

- **To provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, medications, and other matter relating to your health**
- **To follow the treatment plan recommended by the practitioner responsible for your care; and for your actions if you refuse treatment or do not follow the practitioner's instructions.**
- **To keep appointments and when unable to do so for any reason, to notify the attending practitioner.**
- **To ensure that the financial obligations of your health care after fulfilled as promptly as possible.**
- **To be considerate of the right of other patients and personnel and for assisting in the control of noise, and smoking**
- **To be respectful of the property of others.**
- **To ask for clarification when explanation regarding your treatment have not been given to your satisfaction**

ABOUT ADVANCE DIRECTIVIES

Upon registrations, we will ask you if you have an advance directive. An advance directive is a written document which communicates your health care wishes clearly. A copy of your advance directive must be placed in your medical record. There are two types of advance directives:

- **A durable Power of Attorney for Health Care**

Is a document that allows you to designate another person (known as a proxy agent) who is at least 18 years of age to make medical decisions for you in the event you are unable to do so. These decisions may include, but are not limited to the withholding or withdrawal of life prolonging procedures.

- **A Living Will or Health Care Directive**

Is a document that allows you to state in advance your wishes regarding the use of certain medical procedures and treatments and becomes effective when you are unable to make your own decisions and can no longer communicate such decisions. It serves as a guide to your family or the person you name as your agent.

Name of Patient	**Signature of Patient**	**Date**	**Time**
Name of Legal Authorized Person	**Signature of Legal Authorized Person**	**Date**	**Time**
Name of Witness	**Signature of Witness**	**Date**	**Time**

BRAND TARZANA SURGICAL INSTITUTE

RESUSCITATIVE MEASURES

NOT A REVOCATION OF ADVANCED DIRECTIVES OR MEDICAL POWER OF ATTORNEY

ALL PATIENTS HAVE THE RIGHT TO PARTICIPATE IN THEIR OWN HEALTH CARE DECISIONS AND TO MAKE ADVANCED DIRECTIVES OR TO EXECUTE POWERS OF ATTORNEY THAT AUTHORIZE OTHERS TO MAKE DECISIONS ON THEIR BEHALF BASED UPON THE PATIENTS EXPRESSED WISHES WHEN THE PATIENT IS UNABLE TO MAKE DECISIONS OR UNABLE TO COMMUNICATE DECISIONS. THIS SURGERY CENTER REPECTS AND UPHOLDS THOSE RIGHTS.

HOWEVER, UNLIKE IN AN ACUTE CARE HOSPITAL SETTING, THE SURGERY CENTER DOES NOT PERFORM ANY "HIGH RISK" PROCEDURES. THE VAST MAJORITY OF ALL PROCEDURES PERFORMED IN THE FACILITY ARE CONSIDERED TO BE MINIMAL RISK AND MANY ARE ELECTIVE. OUR STAFF AND EACH PATIENT EXPECTS TO RETURN HOME WITHIN HOURS OF HIS OR HER PROCEDURE FULLY RECOVERED AND CAPABLE OF FULL RECOVERY AT HOME WITHIN MINIMAL FOLLOW-UP CARE.

IT IS OUR POLICY, REGARDLESS OF THE CONTENT OF ANY ADVANCED DIRECTIVE OR INSTRUCTIONS FROM A HEALTH CARE SURROGATE OR ATTORNEY IN FACT, THAT IF IN AN ADVERSE EVENT OCCURS DURING YOUR TREATMENT AT THIS FACILITY, WE WILL INITIATE RESUSCITATIVE OR OTHER STABALIZING MEASURES TO TRANSFER YOU TO AN ACUTE CARE HOSPITAL FOR FURTHER EVALUATION. AT THE ACUTE CARE HOSPITAL, FURTHER TREATMENT OR WITHDRAWAL OF TREATMENT MEASURES ALREADY BEGUN WILL BE ORDERED IN ACCORDANCE WITH YOUR WISHES, ADVANCE DIRECTIVE OR HEALTH CARE POWER OF ATTORNEY.

IF YOU DO NOT AGREE WITH THI POLICY WE ARE PLEASED TO ASSIST YOU WITH RESCHEDULING THE PROCEDURE.

PLEASE CHECK THE APPROPRIATE BOX IN ANSWER TO THESE QUESTIONS.

HAVE YOU EXECUTED AN ADVANCED HEALTHCARE DIRECTIVE, A LIVING WILL, OR A POWER OF ATTORNEY THAT AUTHORIZES SOMEONE TO MAKE HEALTHCARE DESCISONS FOR YOU?

☐ YES, I HAVE AN ADVANCED DIRECTIVE OR HEALTHCARE POWER OF ATTORNEY ☐ COPY ON CHART ☐ NO

☐ NO, I DO NOT HAVE AN ADVANCED DIRECTIVE OR HEALTHCARE POWER OF ATTORNEY

☐ I WOULD LIKE TO HAVE INFORMATION ON ADVANCED DIRECTIVES ☐ PROVIDED

IF YOU ANSWERED "YES" TO THE FIRST QUESTION ABOVE, PLEASE PROVIDE US A COPY OF THAT DOCUMENT SO THAT IT MAY BE MADE PART OF YOUR MEDICAL RECORD.

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENT AND AGREE TO THE POLICY AS DESCRIBED. IF I HAVE INDICATED I WOULD LIKE ADDITIONAL INFORMATION, I ACKNOWLEDGE RECEIPT OF THE INFORMATION.

_____ _____ _____

PATIENTS NAME PATIENTS SIGNATURE DATE

IF CONSENT TO THE PROCEDURE PROVIDED BYANYONE OTHER THAN THE PATIENT, THIS FORM MUST BE SIGNED BY THE PERSON PROVIDING THE CONSENT OR AUTHORIZATION.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENT AND AGREE TO THE POLICY AS DESCRIBED.

_____ _____ _____

NAME SIGNATURE DATE

Relationship to patient- ☐ COURT APPOINTED GUARDIAN ☐ ATTORNEY IN FACT
☐ HEALTHCARE SURRGOGATE ☐ OTHER _____