IMPORTANT: Please Bring Packet on Day of Surgery

Directions

From Gwinnett County: Take I-85 South to 285 Westbound. Take exit 28 (Peachtree Dunwoody Exit). Take a left at the end of the ramp and go under I-285. You'll come to the third light and make a left. (Just before the St. Joseph Hospital Campus). You will see the MARTA station entrance and the St. Joseph Glass Building. Come towards the building until you enter our parking deck, which is just up the ramp. We are on the 9th floor of the 5673 Building.

From Downtown: Take I-85 North to GA 400 (Exit 87). Take exit 3 (Glenridge Connector/Glenridge Drive/Road) and make a right on Glenridge Road. Go to Peachtree Dunwoody Road and turn left. At 3rd traffic light turn right. You will see the MARTA station entrance and the St. Joseph Glass Building. Come towards the building until you enter our parking deck, which is just up the ramp. We are on the 9th floor of the 5673 Building.

From Marietta, Smyrna and Chattanooga: Take I-75 South to I-285 East. Take exit 26 (Glenridge Connector). Take a right at the end of the ramp (Glenridge Drive/Road). Turn left onto Peachtree Dunwoody Road. At 3rd traffic light turn right. You will see the MARTA station entrance and the St. Joseph Glass Building. Come towards the building until you enter our parking deck, which is just up the ramp. We are on the 9th floor of the 5673 Building.

From Birmingham and All Points West of the Hospital: Take I-20 East to I-285 North (past I-75). Take exit 26 (Glenridge Connector). Turn right at the end of the ramp (Glenridge Road). Turn left onto Peachtree Dunwoody Road. At 3rd traffic light turn right. You will see the MARTA station entrance and the St. Joseph Glass Building. Come towards the building until you enter our parking deck, which is just up the ramp. We are on the 9th floor of the 5673 Building.

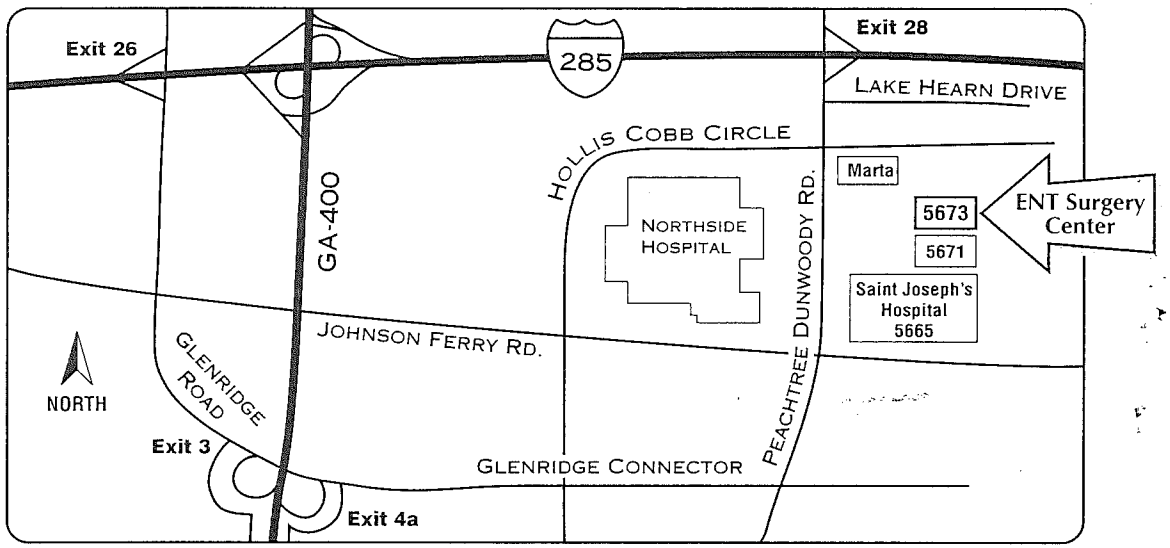
From Augusta and All Points East of th Hospital: Take I-20 West to I-285 North (past I-85, I-285 will become West). Take exit 28 (Peachtree Dunwoody Exit). Take a left at the end of the ramp and go under I-285. You'll come to the third light and make a left. (Just before the St. Joseph Hospital Campus). You will see the MARTA station entrance and the St. Joseph Glass Building. Come towards the building until you enter our parking deck, which is just up the ramp. We are on the 9th floor of the 5673 Building.

From Alpharetta: Take 400 South to exit 4C (HAMMOND DRIVE). Turn left onto Hammond Drive. Turn right onto Peachtree Dunwoody Rd. At the 5th traffic light make a left. (You will see the MARTA station entrance and the St. Joseph Professional Building (glass building). Come up the ramp towards the glass building until you enter the parking deck. Take the elevators to the 9th floor of the 5673 building.

ENT Surgery Center of Atlanta, LLC

5673 Peachtree-Dunwoody Rd., Suite 945
Atlanta, Georgia 30342
404 297-1334

These instructions are intended to make your surgical experience as pleasant as possible. After reviewing them, if you have any questions, please call.



WARNING!

According to New Government Rules, you must contact ENT Surgery Center of Atlanta *(either by phone or in person)* PRIOR to the date of your procedure. Failure to make contact with the surgery center will result in a rescheduling of your procedure.

ENT Surgery Center of Atlanta: 404-297-1334
Hours: M-F 6am-6pm
ASK FOR PRE-OP NURSE

PATIENT EMERGENCY CONTACT FORM

ENT Surgery Center of Atlanta
5673 Peachtree Dunwoody Road, Suite 945
Atlanta, Georgia, 30342
Phone: 404-297-1334
Fax: 404-943-9691

Thank you for choosing ENT Surgery Center of Atlanta. In order to provide the best experience possible, we ask that at least one family member or transportation person remain at the Surgery Center during your procedure. Your Doctor will speak with your family immediately following surgery.

Please take a few moments to fill in the following important information:

Patient Name: _____

Name of Family/Ride: _____

Relationship: _____

Cell Phone: _____

Signature of Family/Ride: _____

ENT Surgery Center of Atlanta LLC

INFORMED CONSENT TO TREAT AND DISCLOSE INFORMATION

To Our Patient:
You have the right as a patient to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be performed so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby consent to the performance of operations and procedures in addition to or different from those now planned whether or not arising from presently foreseen conditions, which the doctor named below or his associates or assistants may consider necessary or advisable during the operation or procedure.

I voluntarily request Dr. _____ as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition. I understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I voluntarily consent and authorize those procedures: **SEE CONSENT**

I understand that:

_____ **I acknowledge that I have been informed, prior to my surgery date, that**

- **Physicians rendering services to me are owners of ENT Surgery Center, LLC.**
- The practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any Procedures.

(Initials)

_____ **I** ☐ **(do)** ☐ **(do not)** consent to the transfusion of blood, blood components as deemed necessary.

_____ **I** ☐ **(do)** ☐ **(do not)** hereby consent to the withdrawal of a blood sample from my body in the event that an employee or physician has had an accidental needle puncture or mucous membrane exposure to my blood or body fluid. I also understand that if an accidental contact does occur, that any blood drawn will be tested and handled in a manner that protects my privacy and identity. No results of any tests done on my blood will be released or shown to any unauthorized person without my written authorization.

I ☐ **(do)** ☐ **(do not)** understand that I am scheduled to go home after my surgery and I must have a responsible adult drive me home and stay with me as advised by my physician.

_____ I understand the surgery is intended to be performed on an outpatient basis. I consent to my transfer to a hospital or other facility should my physician(s) deem it advisable or necessary.

The nature, purpose, and possible complications of the procedure and medical services described above; risks and benefits reasonably expected; and the alternative methods of treatment have been explained to me by the physician; and I understand the explanation I have received.

_____ I understand the Surgery Center is not responsible or liable for the loss of or damage to any article of value that I brought to the center.

_____ Because of the possible adverse effects of some medications on an unborn fetus, it is important to know if the patient is pregnant. Therefore, I certify that to the best of my knowledge I am not (the patient is not) pregnant.

Pregnancy Testing: I request and consent to the Surgery Center performing a urine pregnancy test, as part of the Surgery Center's routine pre-operative lab work due to the possible risks of anesthesia and certain medications on an unborn fetus, including birth defects and miscarriage. I understand a urine pregnancy test is generally accurate, but no pregnancy test is 100% reliable, and there is a possibility this test could miss an early pregnancy or have a false positive result. ***If the Patient believes she might be pregnant, it is her responsibility to notify her attending physician and anesthesiologist before any medication or anesthesia is given.***

In consideration of the services to be rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the patient's account at the rates stated in the Surgery Center's price list (known as the "Charge Master") effective on the date of service, which rates are hereby expressly incorporated by reference as the price term of this Agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or the charge is listed as zero. In the event that the Surgery Center has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented to herein, the undersigned agrees to the attorney's fees and collection expenses incurred by the Surgery Center.

An estimate of the anticipated charges for services to be provided to the patient is available upon request from the Surgery Center. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

We may use or disclose information about you to bill or receive payment for medical treatment or services provided to you. These disclosures include releasing information;

(1) to your health plan to obtain prior approval or to determine whether your plan will cover the treatment or services; or

(2) to individuals or entities involved in collecting amounts owed to us.

Some or all of the health care professionals performing services in the Ambulatory Surgery Center are independent contractors and are not Surgery Center agents or employees. Independent contractors are responsible for their own actions and the Surgery Center shall not be liable for the acts or omissions of any such independent contractors.

Signature ✕ _____ _____ _____ _____

Patient Date Witness Time

(if the patient is a minor or unable to sign, complete the following)

☐ Patient is a minor

☐ Patient is unable to sign because _____

_____

_____

(Print Patient Name) (Print Parent Name) Legally Designated Representative

Signature _____

ENT Surgery Center of Atlanta LLC

Peachtree Dunwoody Road, Suite 945 • Atlanta, GA

PATIENT INFORMATION

I request that payment of authorized benefits be made to **ENT SURGERY CENTER OF ATLANTA, LLC.** I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits or the benefits payable for related services.

DATE _____ **SIGNATURE** _____

I hereby authorize the release of any confidential information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to **ENT SURGERY CENTER OF ATLANTA, LLC** for all medical and/or surgical benefits including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance program, or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to **ENT SURGERY CENTER OF ATLANTA, LLC** by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective as the original. I understand that I have the right to receive a copy of this authorization.

SIGNATURE OF PERSON PROVIDING AUTHORIZATION _____

RELATIONSHIP TO PATIENT IF NOT PATIENT _____

DATE _____

ALTERNATIVE CONTACT AUTHORIZATION

☐ **DO** ☐ **DO NOT** authorize **ENT SURGERY CENTER OF ATLANTA, LLC.** to contact me or leave messages for me at my place of work. Date: _____ Initials: _____

I hereby authorize **ENT SURGERY CENTER OF ATLANTA, LLC.** to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are available. I realize I must call the office to obtain laboratory results.

Date: _____ Initials: _____

I ☐ **DO** ☐ **DO NOT** authorize **ENT SURGERY CENTER OF ATLANTA, LLC.** to discuss my appointments, medical evaluation, treatment and results to relatives or other persons indicated.

Authorized person(s)/relationship: _____

Date: _____ Initials: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that, prior to my surgery date, I have received a copy of the **"Notice of Privacy Practices"**, **"Patient Rights and Responsibilities"** & the **"Financial Policy"** for my records.

Date: _____ Initials: _____

LIVING WILL/ADVANCE DIRECTIVES

ENT Surgery Center of Atlanta is NOT an acute care facility; therefore, regardless of the contents of any advanced directive or instructions from a health care surrogate or attorney, if any adverse event occurs during your treatment, we will initiate resuscitative or any other stabilizing measures and transfer you to an acute care setting for further evaluation. Your agreement with this policy does not revoke or invalidate any current health care directives or health care power of attorney.

I also acknowledge I have been provided with information, prior to my surgery date, of the need for a Living Will/Advanced Directives and that I understand information is available to me if needed.

Date: _____ Initials: _____

INFECTION CONTROL PROGRAM

HERE'S HOW YOU SHOULD WASH YOUR HANDS WITH HAND SANITIZERS (Waterless Hand Cleaners):

- Follow the instructions on the product on how much to use.
- Apply product to the palm of your hand.
- Rub your hands together. Cover all surfaces of your hands and fingers until they are dry. Be sure to get under your fingernails.

STANDARD PRECAUTIONS

Health care staff often wear gloves, gowns, masks or eye protection. Staff may wear some of these protective items while caring for you. This practice is called "standard precautions" (pree-CAW-shuns). This practice protects all patients and staff from germs and infections.

SPECIAL PRECAUTIONS

Sometimes a patient has an infectious disease that can easily spread to other people. While it is our policy NOT to treat people with infectious diseases in our Center, you should be aware of what *"special precautions"* are. These are utilized to protect others from the infectious disease. These special practices prevent the spread of germs that cause the disease. If you have a known or suspected infection that requires special precautions, please notify your nurse so you can be scheduled in a more appropriate setting.

IF YOU HAVE QUESTIONS

We want your stay to be as pleasant as possible. It is important that you understand the need for hand washing, standard precautions, and special precautions. If you have any questions, please ask your nurse or doctor.

Thank you for your consideration!

ENT Surgery Center of Atlanta LLC

5673 Peachtree Dunwoody Road, Suite 945 • Atlanta, GA 30342

INFECTION CONTROL PROGRAM

GERMS AND INFECTION

We at **ENT Surgery Center of Atlanta, LLC** (the "Center) work hard to prevent the spread of infection. Germs and infections can travel from patient to patient, from patient to staff and visitors, or from staff to patients and visitors.

This information sheet tells you about guidelines to reduce your risk of infection while you are in our Center or at any other health care center. If you are feeling ill, please do not come to the Center; instead, reschedule your procedure if you are to have a procedure or have someone else pick up a patient undergoing a procedure.

Please follow these simple guidelines:

WASH YOUR HANDS

The most important step to prevent the spread of germs and infections is hand washing. Wash your hands often. Be sure to wash your hands each time you:

- touch any blood or body fluids;
- touch bedpans, dressings, or other contaminated items;
- use the bathroom or bedpan; and
- cough, sneeze or blow your nose

ALWAYS wash your hands before you eat.

HERE'S HOW YOU SHOULD WASH YOUR HANDS WITH SOAP AND WATER:

- Wet your hands and wrists with warm water
- Use soap. Work up a good lather, and rub hard for 15 seconds or longer. Be sure to clean under your fingernails.
- Rinse your hands well.
- Use a clean paper towel to turn off the water. Throw the paper towel away.

NOTICE OF PRIVACY PRACTICES

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that our Medical Director review the denial. Another licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

- **Right to Amend.** If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as we maintain your medical record.

  To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: 1) Was not created by us, unless the person or entity that created the information is no longer available to make the amendment; 2) Is not part of the medical information kept by us or for us; 3) Is not part of the information which you would be permitted to inspect and copy; or 4) Is inaccurate and incomplete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures" made by us after April 14, 2003. This is a list of the disclosures we made of medical information about you to others that are not involved with your treatment, payment of services rendered to you or health care operations as previously defined in this Notice of Privacy Practices.

  To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member of friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

  We are not required to agree to your request and we may not be able to comply with your request. If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is excepted from the consent requirement or we are otherwise required to disclose the information by law.

  To request restrictions, you must make your request **in writing.** In your request, you indicate: 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply, (e.g. disclosures to your children, parents, spouse, etc.)

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or email, or the like. To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all *reasonable* requests. Your request must specify how or where you wish us to contact you.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Investigation and Government Activities: We may disclosure medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in a response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official: 1) In response to a court order, subpoena, warrant, summons or similar process; 2) To identify or locate a suspect, fugitive, material witness, or missing person; 3) About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; 4) About a death we believe may be the result of criminal conduct; 5) About criminal conduct at the Practice; and 6) In emergency circumstances to report a crime; the location of the crime or victim; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Center (and Medical Practice) to funeral directors as necessary to cary out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution, or law enforcement official. This release would be necessary: 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the corrections institutions.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact either the Clinical Supervisor or the Administrator, who will direct you on how to file a complaint. All complaints must be submitted in writing, and all complaints shall be investigated upon receipt and will have a written response sent to the patient regarding the resolution of the complaint within one (1) week of receiving the complaint, without repercussion to you. The Clinical Supervisor can be reached at this number, **404-297-1332**. The Administrator can be reached at this number, **404-297-6106**. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND OUR OBLIGATIONS REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

  To inspect and copy your medical record, you must submit your request in writing to our Clinical Supervisor. Ask the front desk person for the name of the Clinical Supervisor. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

NOTICE OF PRIVACY PRACTICES

Payment. We may use and disclose medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at our facility/office, to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician, or the like.

Health Care Operations. We may use and disclose medical information about you so that we can run our operations more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

We may also use or disclose information about you for internal or external utilization review and/or quality assurance, to business associates for purposes of helping us to comply with our legal requirements, to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor, at all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your medical records.

Appointment and Patient Recall Reminders. We may ask that you sign in at the Receptionists' Desk, a "Sign In" log on the day of your appointment with us. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with us or that you are due to receive periodic care from us. This contact may be by phone, in writing, email, or otherwise and may involve the leaving of an email, a message on an answering machine,or otherwise which could (potentially) be received or intercepted by others. Please let us know in writing if this is not acceptable or if there is another telephone number, email address, or other method of notification you prefer.

Emergency Situations. In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will obtain an Authorization from you before using or disclosing your individually identifiable health information unless the authorization requirement has been waived. If possible, we will make this information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for use or disclosure is not required.

Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following: 1) to prevent or control disease, injury or disability; 2) to report births and deaths; 3) to report child abuse or neglect; 4) to report reactions to medications or problems with products; 5) to notify people of recalls of products that may be using; 6) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; 7) to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

ENT Surgery Center of Atlanta LLC

5673 Peachtree Dunwoody Road, Suite 945 • Atlanta, GA 30342

NOTICE OF PRIVACY PRACTICES

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

IF YOU HAVE ANY QUESTIONS ABOUT ANY PART OF THIS NOTICE, PLEASE ASK TO SPEAK TO THE CLINICAL SUPERVISOR OR ADMINISTRATOR

This notice of Privacy Practices describes how we may use and disclose your protected health information needed to treat you, obtain payment for services, for health care operations and for other purposes permitted by law. The term "protected health information" means any information about you, including information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

We provide this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We are required to comply with the terms of this Notice of Privacy Practices.

This Notice of Privacy Practices will apply to: 1) Any health care professional authorized to enter information into your chart (including physicians, PAs, RNs, etc.); 2) All areas of our operations (front desk, administration, billing and collection, etc.); 3) All of our employees, staff and other personnel that work for or with us; 4) Our business associates (including a billing service, or facilities to which we refer patients), on-call physicians, and so on.

CHANGES TO OUR NOTICE OF PRIVACY PRACTICES

We may change the terms of this Notice at any time. The new notice will be effective for all protected health information about you. You should be comfortable in sharing any information about your health with your doctor in order to help him/her provide the most appropriate health care. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

All of our medical and administrative staff understands that we are required by law to: 1) make sure that the protected health information about you is kept private; 2) provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and 3) follow the conditions of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following are examples of different ways that we use and disclose protected health information that we have and share with others. Each type of use or disclosure provides a general explanation and provides some examples of uses. This list does not include every potential use or disclosure of information in a category. The explanation is provided only to help you understand how the practice may use or disclose your protected information in compliance with any authorizations or consents required by law.

Medical Treatment. We will use medical information about you that was on file prior to and which may obtained after this Notice to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. Therefore we may, and most likely will, disclose medical information about you to doctors, nurses, laboratory or imaging technicians, medical students, hospital or home health personnel who are involved in taking care of you. We may also disclose information to other doctors who may be treating you or to who we may refer you for care. These doctors may need information from your medical record to provide appropriate care.

Different areas of our operations also may share medical information about you including your record(s), prescriptions, requests for lab work and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside our practice who may be involved in your medical care after you leave our facility/office; this may include your family members, or other personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent).

ENT Surgery Center of Atlanta LLC

5673 Peachtree Dunwoody Road, Suite 945 • Atlanta, GA 30342

FINANCIAL POLICY

If you have medical insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

- Co-payments and/or deductibles, which have not been met, are required at the time you register.
- As a courtesy, we will process and file your insurance claims at no cost to you.
- For services that are not covered by insurance, we require payment of 100% of the total charges unless payment arrangements have been worked out.
- Returned checks are subject to a handling fee of $25.00. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.
- **Anesthesia, Surgeon, Pathology and/or Lab work will be billed directly to your insurance company and are separate from the surgical services charges.**

You must realize that:

1. Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

Your account is due in full upon receipt of statement, we realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We will allow you 60 days to pay any balance remaining after insurance payment. After that time, your account will accrue interest at the rate of 1.5% per month (18% annually, 19.56% APR). Our staff will make arrangements for monthly payments over an approved term.

ENT Surgery Center of Atlanta LLC

5673 Peachtree Dunwoody Road, Suite 945 • Atlanta, GA 30342

PATIENT RIGHTS & RESPONSIBILITIES

PATIENT RIGHTS

1) The privacy of all patients shall be respected at all times. Patients shall be treated with respect, consideration and dignity.
2) Patients shall receive assistance in a prompt, courteous, and responsible manner.
3) Patient medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patients' and/or designated representatives' express written approval.
4) Patients have the right to know the identity and status of individuals providing services to them.
5) Patients have the right to change providers if they so choose.
6) Patients, or a legal authorized representative, have the right to thorough, current and understandable information regarding their diagnosis, treatment options and prognosis, if known, and follow-up care. All patients will sign an informed consent form after all information has been provided and their questions answered.
7) Patients have the right to refuse treatment and to be advised of the alternatives and consequences of their decisions. Patients are encouraged to discuss their objectives with their provider.
8) Patients have the right to refuse participation in experimental treatment and procedures. Should any experimental treatment or procedure be considered, it shall be fully explained to the patient prior to commencement.
9) Patients have the right to express complaints about the care they have received and to submit their grievance to the Administrator (Deborah Smith @ 404-297-6106, dsmith@entofga.com) who will complete an "Incident Report" and bring the issue to the attention of the Medical Director in a timely manner so the grievance may be addressed. If the issue is not resolved to the Patient's satisfaction, Patient has the right to call the Office of Civil Rights at 404-347-3125.
10) Patients have the right to be provided with information regarding emergency and after-hours care.
11) Patients have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the expense of the second opinion rests solely with the patient.
12) Patients have the right to a safe and pleasant environment during their stay.
13) Patients have the right to have procedures performed in the most painless way possible.
14) Patients have the right to an interpreter if required.
15) Patients have the right to be provided informed consent forms as required by the laws of the State of Georgia.
16) Patients have the right to have visitors at the Center as long as visitation does not encumber Center operations and the rights of other patients are not infringed.
17) Patients have the right to develop Advance Directives which will be respected by Center staff.
18) Patients will be provided, upon request, all available information regarding services available at the Center, as well as information about estimated fees and options for payment.

PATIENT RESPONSIBILITIES

1) Patients are expected to provide complete and accurate medical histories including providing information on all current medications, keep all scheduled pre- and post-procedure appointments and comply with treatment plans to help ensure appropriate care.
2) Patients are responsible for reviewing and understanding the information provided by their Physician or nurse.
3) Patients are responsible for understanding their insurance coverage and the procedures required for obtaining coverage.
4) Patients are responsible for providing insurance information at the time of their visit and to notify the receptionist of any changes in information regarding their insurance or medical information.
5) Patients are responsible for paying all charges for co-payments, co-insurance, deductibles on non-covered services at the time of the visit unless other arrangements have been made in advance with the Medical Practice.
6) Patients are responsible for treating Center Physicians and Staff in a courteous and respectful manner.
7) Patients are responsible for asking questions about their medical care and to seek clarification from their physician of the services to be provided until they fully understand the care they are to receive.
8) Patients are responsible for following the advice of their provider and to consider the alternatives and/or likely consequences if they refuse to comply.
9) Patients are responsible for expressing their opinions, concerns or complaints in a constructive manner to the appropriate personnel at the Center.
10) Patients are responsible for notifying their health care providers of patient's Advance Directives.

NORTHSIDE ANESTHESIOLOGY CONSULTANTS LLC
PO Box 116443
Atlanta, Georgia 30368-6443

Providing Professional Anesthesia Services for patients of
ENT SURGERY CENTER OF ATLANTA, LLC

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to Northside Anesthesiology Consultants LLC, (Practice), all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of Practice charges for this admission or other amounts as may be provided by an agreement between the Practice and my insurance company). I authorize and direct the insurance company to pay all such benefits to the Practice. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and the Practice.

Authorization to Release Claims Information: I hereby authorize the Practice, it employees and agents, to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the propose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare) or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I hereby authorize the Practice, its employees and agents to act on my behalf in completing claims.

Precertification & Financial Responsibility: I understand that my insurer may require compliance with utilization review (UR) program to ensure that plan benefits are justified. I understand that it is the insurer's UR program's responsibility to review proposed elective admissions and anticipated courses of treatment. I understand that if the UR program determines that the admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, healthcare benefits may be withheld. I understand that the Practice is willing to provide professional anesthesia services as requested by my attending physician. I also understand that I may be financially responsible for all related charges incurred as a result of this admission should the UR review program refuse to certify that the admission or a specific service was appropriate, or should the certification effort occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company, UR program and personal physician without delay and in advance of my admission.

Signature of Patient/Authorized Guardian Signature **Date**

PATIENT NOTICE REGARDING ANESTHESIA SERVICES

ANESTHESIA SERVICES ARE PROVIDED AT ENT SURGERY CENTER OF ATLANTA LLC BY PRACTICE, AND ITS EMPLOYEES ARE INDEPENDENT HEALTH PROVIDERS AND ARE NOT EMPLOYEES OR AGENTS OF ENT SURGERY CENTER OF ATLANTA LLC. PRACTICE EMPLOYS CERTIFIED REGISTERED NURSE ANESTHETISTS AND PHYSICIAN ASSISTANT ANESTHESIOLOGY ASSISTANTS AS PART OF THE ANESTHESIA CARE TEAM.

ANESTHESIA SERVICES WILL BE BILLED SEPARATELY FROM THE SERVICES OF ENT SURGERY CENTER OF ATLANTA LLC

FOR AN ESTIMATE OF ANESTHESIA CHARGES, OR OTHER BILLING QUESTIONS, CALL 770-645-7889.