SOUTH PORTLAND SURGICAL CENTER
6370 SW Borland Road Suite 100
Tualatin, OR 97062
Phone: 503-218-1105

Welcome!

On behalf of the entire staff, we welcome you and look forward to your upcoming visit at South Portland Surgical Center. Our staff is dedicated to providing individualized, high quality medical care in a confidential, caring, and respectful environment.

We have enclosed the following documents for you to review, complete and bring with you to your appointment:

- South Portland Surgical Center Brochure
- Registration Form
- Financial/Billing Policy
- Patient Medication Reconciliation

Please help us better serve you and make your admission process as easy as possible by reading all the enclosed forms and completing all enclosed forms before you arrive at our facility. Please remember to complete the Patient Medication Reconciliation form in its entirety, including dose, frequency, date/time last taken, route and the purpose for use.

Financial/Billing Information: South Portland Surgical Center is in-network with most major insurance plans. You may be contacted by our team to review benefits and discuss financial responsibility prior to your procedure. If you have questions about your financial responsibilities, please call us and our financial coordinators will be happy to assist you.

For assistance with the doctor's fees please contact their office. For questions regarding the anesthesiologist fees please contact Oregon Anesthesiology Group (OAG) at 503-299-9906.

Pre-Op Screening Call: You will receive a call from a nurse at our facility prior to your appointment to review your medical history, medications and give preparation instructions for the procedure. We recommend having your registration forms completed prior to that call to expedite the process. If you have not received a call 24 hours prior to your procedure, please contact us.

Surgery Times: Surgery times are subject to change for a variety of reasons up to the day before surgery. In an effort to reduce confusion, we will call you the day before your surgery with a confirmed arrival time. If you have not received a call by 2pm, please call our scheduling team at 503-905-3708.

We hope you will find the care you receive at South Portland Surgical Center a pleasant experience. The staff are grateful to care for you or your family member and hope for a smooth and speedy recovery.

Sincerely,

The Physicians and Staff of South Portland Surgical Center

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REGISTRATION FORM

Last Name _____ First Name _____ MI _____

Address _____
(Street) (City) (State) (Zip)

Mailing Address _____
(City) (State) (Zip)

Cell Phone _____ Home Phone _____ Work Phone _____

Date of Birth _____ Email Address _____

Employer _____ Occupation _____

In case of emergency, contact:

Name _____ Relationship _____

Daytime Phone # _____ Cell Phone # _____

Responsible Party (if not patient):

Last Name _____ First Name _____ MI _____

Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Medical Insurance Information (please fill out COMPLETELY):

Primary Insurance _____ ID# _____ Group # _____

Subscriber _____ Subscriber DOB _____

Relationship to patient _____ Employer _____

Secondary Insurance _____ ID# _____ Group # _____

Subscriber _____ Subscriber DOB _____

Relationship to patient _____ Employer _____

Is your procedure related to a workers compensation injury or motor vehicle accident? Y N

Workers Compensation / Motor Vehicle Accident / Third Party Liability / Lawsuit (please fill out COMPLETELY):

Insurance Company _____ Phone # _____

Claim# _____ Date of Accident/Injury _____

Adjuster Name _____ Phone # _____

Name of Attorney _____ Phone #_____ Fax #_____

Address of Attorney _____

SOUTH PORTLAND SURGICAL CENTER

Release of Information and Conditions of Admission

(patient initial by each consent)

Initials

_____ **Release of Information**

I hereby authorize SPSC, LLC to provide all the patient's recorded information included in the medical record to the patient's insurance company.

_____ **Transfer of Information**

I hereby consent to the release and transfer of records in the unlikely event it becomes medically necessary for transfer of patient to hospital while in the care of SPSC, LLC. I further consent to the release of the hospital discharge records to SPSC, LLC upon discharge from the hospital.

_____ **Authorized Personnel**

I hereby authorize personnel requested and approved by my surgeon and South Porland Surgical Center management to be in the operating room.

_____ **Authorized Imaging**

I hereby consent to the use of imaging during my procedure, if necessary. I consent to the images being taken during my procedure by my physician or a designee approved by my physician for the purpose of medical treatment. I consent that these images will become part of my medical record. Examples of imaging needed during surgery: Fluoroscopic imaging (X-ray), arthroscopic video and picture imaging and ultrasound imaging.

_____ **Assignment of Benefits**

I hereby authorize my Insurance company to make payment directly to South Portland Surgical Center, LLC for the medical and surgical benefits allowable and otherwise payable to me under the current insurance policy. I have received a copy of the Financial Agreement.

Oregon Anesthesiology Group

Oregon Anesthesiology Group, P.C.
Assignment of Benefits and Communications

South Portland Surgical Center contracts with Oregon Anesthesiology Group, P.C. to provide an anesthesiologist for your procedure. *Oregon Anesthesiology Group, P.C.* will send you a separate bill for these services.

Assignment of Benefits

For services rendered, I hereby assign to and authorize payment directly to *Oregon Anesthesiology Group, P.C.* of all benefits due to me under Medicare, Medicaid, or any insurance policy providing benefits for anesthesia professional services.

Communications

I acknowledge that South Portland Surgical Center and *Oregon Anesthesiology Group, P.C.* may contact me by phone or through any electronic communication methods linked to me, including mobile numbers. I understand they may leave voicemail, text, or email messages containing information permitted by law (including under debt collection laws) about services provided to me or any amounts I may owe.

_____ _____

Signature of Patient or Responsible Party Date

_____

Name of Patient or Responsible Party

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503.218.1105

SOUTH PORTLAND SURGICAL CENTER

FINANCIAL / BILLING POLICY

Please read the following information carefully as it applies to your financial responsibility.

Thank you in advance for your cooperation.

Understanding Your Insurance

Your medical insurance policy is a contract between you and your insurance carrier and South Portland Surgical Center is not a party to that contract. As a result, your coverage and responsibilities are determined by your policy and you are responsible for understanding and following their procedures. On your behalf, the Center will submit all your claims to your primary, secondary and tertiary insurance providers.

It is your responsibility to provide us with sufficient, accurate and up-to-date insurance and mailing address information. If your insurance carrier does not submit payment, you are liable for your entire account balance. It is your responsibility to contact your insurance carrier with any questions and to respond to any inquiries from them in a timely manner regarding your condition or procedure.

The Cost of Your Procedure

Once we receive your scheduling and insurance information from your surgeon's office, South Portland Surgical Center will contact your insurance carrier and verify eligibility and medical coverage for services at an Ambulatory Surgery Center.

Co-Payments, Deductibles and Estimated Co-Insurance amounts are due on the day of your surgery. If there is any anticipated patient responsibility you may be contacted by a Financial Coordinator to discuss these estimated costs before your scheduled procedure. If you have any questions, please call the business office at 503-218-1105.

Please note: You may receive up to 5 separate bills associated with your surgery. These include the Facility Fee, Surgeons Fee, Anesthesiologist Fee, Pathology/Lab Fee and Durable Medical Equipment (DME) if applicable.

Payment Responsibility

After your insurance has been billed, you remain responsible for the full balance. You will receive a statement in the mail and payment is due in full within 30 days. For your convenience we accept Cash, Check, Cashier's Check, Money Order, Visa, Mastercard, Discover, American Express and CareCredit. (There will be an NSF Charge for any Returned Checks).

If you are not covered by medical insurance or choose not to utilize your medical insurance for your surgery, our Center's policy requires payment in full on the day of your procedure. Please contact the Business Office Manager regarding your potential out of pocket costs.

Collections

If balances are not paid in full within 90 days or payment arrangements have not been made with the Financial Coordinator, your account may be referred to a formal collection agency. By signing below, you understand you are solely responsible for all costs, including attorney fees incurred by an outside agency in the collection of the outstanding debt.

Minors

A parent or legal guardian must accompany a minor and consent to treatment, unless otherwise stipulated by law. Parents or legal guardians must comply with the terms of this billing policy. If the parents of a minor are separated/ divorced, the Center has the right to require legal documentation determining which parent is financially responsible for paying the child's medical expenses or responsibility for determining the child's medical care needs. The parent or guardian that accompanies the minor to an office visit will be held responsible for payment of services should any dispute over payment arise.

Pre-Authorization/Pre-Certifications

If your medical insurance plan requires you to have a prior authorization or pre-certification to be on file for a procedure, this should be obtained before your scheduled procedure. The Center makes every attempt to follow-up with your physician's office to see that the authorizations are obtained prior to the surgery; however, the authorization must be obtained by the performing physician.

IF WE DO NOT HAVE THE REQUIRED PRIOR AUTHORIZATION OR PRE-CERTIFICATION; YOU WILL BE FULLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AT THE CENTER.

I have read and acknowledged the Financial/Billing Policy of South Portland Surgical Center and agree to the policies and patient responsibilities.

_____
Patient or Authorized Representative

_____ _____
Print Patient Name Date

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PATIENT MEDICATION RECONCILIATION

Include OTC, Herbals and Dietary Supplements

Drug Name	Dose	Frequency	Date/Time Last Dose	Route	Purpose for Use

Drug **Allergy:** _____ Reaction: _____ Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____ Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____ Drug **Allergy:** _____ Reaction: _____

Patient Signature (or Responsible Party)_____

Ordered at Discharge

Drug Name	Dose	Frequency	Last Dose	Route	Purpose for Use

Sources of Information (check all applicable):

❑ Patient/Family recall

❑ Other (specify): _____

Date/Time initiated/Nurse _____

Post-op RN _____

❑ Patient may resume all medications with the exception of:

_____

Example:

Please fill out this worksheet as much as possible. Below are examples of how your worksheet should look.

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PATIENT MEDICATION RECONCILIATION

Include OTC, Herbals and Dietary Supplements

Drug Name	Dose	Frequency	Date/Time Last Dose	Route	Purpose for Use
Atenolol	25 mg	daily	2/12/18 0500am	oral	Blood Pressure
Albuterol inhaler	2 puffs	as needed	2/10/18 1200pm	inhaler	asthma
Nicotine patch	21 mg	daily	2/12/18 0600am	topical	quit smoking
Ibuprofen	200mg	as needed	2/11/18 7pm	oral	pain
Multivitamin	1 tablet	daily	2/12/18 0900am	oral	health

Drug **Allergy:** Penicillin Reaction: Rash
Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____

Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____

Patient Signature (or Responsible Party) Jane Doe

Ordered at Discharge

Drug Name	Dose	Frequency	Last Dose	Route	Purpose for Use

Sources of Information (check all applicable):

❑ Patient/Family recall

❑ Other (specify): _____

Date/Time initiated/Nurse _____

Post-op RN _____

❑ Patient may resume all medications with the exception of:

_____

SOUTH PORTLAND SURGICAL CENTER - 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.

This Notice applies to ("Center") and health professionals when they provide services at the Center. Under federal law, your health information (known as "PHI") is protected and confidential. PHI includes information about your symptoms, test results, diagnosis, treatment, and related medical information and payment, billing, and insurance information. Your PHI may be stored and disclosed electronically.

How We Use & Disclose Your PHI

Treatment: We will use and disclose your PHI for treatment purposes. For example, nurses, physicians, and other members of your treatment team use PHI to determine the most appropriate course of care. We may also disclose PHI to other health providers who participate in your care.

Payment: We will use and disclose PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing treatment, determine whether you are enrolled or eligible for benefits and submit bills to your health plan.

Health Care Operations: We will use and disclose your PHI to conduct our standard internal operations, including administration of records, credentialing, evaluation of the quality of treatment, arranging for legal services and assessing the care and outcomes of your case and others like it.

The Center and professionals covered by this Notice will share PHI with each other as permitted by law for treatment, for payment, and for the Center's health care operations.

Other Uses and Disclosures We May Make

Family/Friends/Disasters: We may disclose limited PHI to family members or friends who are helping with your care or payment for your care and to those assisting in disaster relief efforts. For example, following a procedure, we will disclose your discharge instructions and PHI related to your care to the individual who is driving you home or who is otherwise assisting in your post-procedure care.

Required by Law: We may disclose your PHI as required by law , such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. For example, we may disclose your PHI to the U.S. Department of Health and Human Services if it requests PHI to determine that we are complying with federal law.

Research: We may use or disclose PHI for approved medical research.

Public health activities: We may disclose vital statistics, disease information, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may disclose PHI to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose PHI in response to an appropriate subpoena, discovery request or court order.

Law enforcement purposes: We may disclose PHI to law enforcement officials as permitted by law, such as to report a crime on our premises.

Deaths: We may disclose PHI regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and special government functions: If you are a member of the armed forces, we may release PHI as required by military command authorities. We may also disclose PHI to correctional institutions or for national security purposes.

Workers compensation: We may release PHI for workers compensation or similar programs providing benefits for work-related injuries or illness.

Business associates: We may disclose PHI to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.

De-identification. We may use and disclose your PHI to create information that is de-identified. In other words, we may remove identifiers in order to create information that is no longer individually identifiable as defined by law. We may also remove most PHI that identifies you from a set of data and use and disclose this data set for research, public health and health care operations, provided the recipients of the data set agree to keep it confidential.

Health information exchanges. We may participate in one or more health information exchanges ("HIEs") and with your consent may electronically share your PHI for treatment and other permitted purposes with other HIE participants. HIEs allow your providers to efficiently access and use your PHI for treatment and other lawful purposes unless you opt out.

In any other case, we will ask for your written authorization before using or disclosing your PHI. If you sign an authorization, you can later revoke that authorization to stop any future uses and disclosures by contacting the Contact Person listed below. Subject to limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your PHI for marketing purposes or sell your PHI, unless you have signed an authorization.

If we receive records from substance use disorder treatment programs subject to federal privacy rules (42 CFR Part 2) such records or testimony about their content cannot be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent or a court order entered after notice and an opportunity to be heard is provided to the individual or us, as provided by 42 CFR Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested substance use disorder record is used or disclosed.

We may use Artificial Intelligence or (AI) tools, for purposes described in this Notice and as permitted by the HIPAA Rules. For example, we may use tools that record your interactions with our providers and staff to assist with drafting notes or scheduling appointments.

Individual Rights

You have the following rights with regard to your PHI. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights. If you have given another individual a medical power of attorney, if another individual is appointed as your legal guardian or is authorized by law to make healthcare decisions for you (known as a "personal representative"), that individual may exercise any of the rights listed below on your behalf.

□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.

□ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

□ You have the right to look at or get a copy of your PHI. There may be a reasonable cost-based charge for copies.

□ You have the right to request that we amend your PHI.

□ You may request a list of disclosures of PHI about you except for disclosures made with your authorization and other exceptions.

□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duties/Changes to this Notice

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured PHI.

We may change this Notice at any time and make the new terms effective for all PHI we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the Contact Person listed below.

Complaints/Contact Person

If you are concerned that we have violated your privacy rights, you may contact the Contact Person listed below. You also complain to the U.S. Department of Health and Human Services. The Contact Person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint. If you have any questions, requests, or complaints, please contact:

Center Privacy Officer (503-218-1105)

INFORMATIONAL PURPOSES ONLY - ACTUAL NOTICE TO BE SIGNED DAY OF SURGERY