ORTHOPAEDIC ASSOCIATES SURGERY CENTER, LLC

PATIENT BILL OF RIGHTS, GRIEVANCE POLICY, OWNERSHIP INFORMATION & NOTICE OF PRIVACY PRACTICES

(I have received a copy of the "Patient Bill of Rights, Grievance Policy, Ownership Information" and "Notice of Privacy Practices" for Orthopaedic Associates Surgery Center, LLC)

PREGNANCY TEST WAIVER

It is recommended that all female patients of childbearing age to take a pregnancy test prior to a surgical procedure and anesthesia. The reason for this precaution is possible harm to any unborn child. If you wish to waive this pregnancy test and assume this risk yourself, releasing Orthopaedic Associates Surgery Center and your physician from all responsibility for any complications that may occur, please sign below.

☐ Not Applicable

CONSENT FOR HIV AND HEPATITIS B+/or C TESTING

I hereby consent to voluntary testing for Human Immunodeficiency Virus (AIDS Virus) AND Hepatitis B+/or C in the event of a blood bourne pathogen exposure occurrence. This consent authorizes the drawing of body fluids for HIV and Hepatitis B+/or C testing on one or more occasions during this course of treatment.

CONSENT FOR RELEASE OF INFORMATION

I authorize the Orthopaedic Associates Surgery Center, LLC physician to disclose complete information concerning their medical findings and treatment of the undersigned, from the initial office visit until the date of conclusion of such treatment to those individuals who, in their determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review. I authorize the release of health information, to include diagnostic tests and general medical history, to be used for pending surgery at Orthopaedic Associates Surgery Center.

CONSENT FOR PHYSICIAN APPROVED OBSERVER IN SURGERY

I authorize the Orthopaedic Associates Surgery Center, LLC physician to determine when the presence of an observer is necessary for the purpose of rendering technical advisory assistance to the physician, educational purposes and/or to support the patient.

ADVANCE DIRECTIVES

An advance directive is a pre-determined, documented, and witnessed decision on the part of a patient and/or patient's designated attorney in fact which is a written instruction, such as a living will or durable power of attorney for healthcare, recognized under State law relating to the provision of healthcare when the individual who has issued the advance directive is incapacitated. Such directives include, but are not limited to: Living Wills or Do Not Resuscitate (DNR) orders. I have been offered information related to advance directives and understand that Orthopaedic Associates Surgery Center, LLC has Georgia Advance Directive for Health Care forms available should I wish to prepare such document. I understand that the Center's policy is to honor an advance directive with the exception of the DNR portion of the advance directive as permitted by Georgia State Statutory law [O.C.G.A. § 31-32-8(2) and O.C.G.A. § 31-32-9(d) (1-2)]. I authorize Orthopaedic Associates Surgery Center, LLC to adhere to its policy that any physician performing any type of procedure at the Center should not effectuate the DNR order portion of an advance directive. I understand that appropriate emergency procedures will be undertaken to resuscitate patients and transfer them to appropriate facilities in the event of deterioration.

UNPLANNED TRANSFER/ADMISSION TO OTHER FACILITY

I authorize the Orthopaedic Associates Surgery Center, LLC physicians to determine when the transfer or admission to another facility is medically necessary.

LAB RELEASE

Please inform our receptionist if your insurance requires your laboratory or x-ray tests to be performed at or sent to a preferred facility. This information will assure that we are working within the guidelines of your insurance company.

If you fail to inform Orthopaedic Associates Surgery Center of any special requirements, your laboratory and x-ray tests will be done at University Hospital. The hospital will bill you for these services.

PAYMENT POLICY: I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM ORTHOPAEDIC ASSOCIATES SURGERY CENTER OF ANY SPECIAL REQUIREMENTS BY MY INSURANCE COMPANY REGARDING THE ABOVE. I ALSO UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL CHARGES, WHICH ARE INCURRED, FOR SERVICES RENDERED. (REGARDLESS OF INSURANCE COVERAGE)

PLEASE CIRCLE ONE OF YOUR CHOICE FOR EACH:

LABORATORY:
QUEST
UNIVERSITY HOSPITAL
LAB CORP
MULLINS LABORATORY
OTHER:_____

RADIOLOGY:
BROWN AND RADIOLOGY ASSOCIATES
UNIVERSITY IMAGING CENTER
OTHER:_____

A responsible adult must remain in the surgery center during your surgery until the physician has talked to them and you are ready for discharge. You must have someone drive you home. Failure to follow these instructions will result in the cancellation of your surgery.

PRINTED NAME: _____

SIGNATURE:_____

WITNESS: _____ DATE:_____ TIME:_____