PAVILION SURGERY CENTER

920 East First Street, Suite P-101 Duluth, MN 55805 Office: 218-279-6200 Toll Free: 1-888-542-2742

The Pavilion Surgery Center is a multi-specialty surgery center established in 2000 by St. Luke's Hospital and physicians. Pavilion provides outpatient surgical services for cosmetic surgery, ENT, general surgery, gynecology, oral/dental surgery, neurosurgery, pain, podiatry, venous surgery urology and gastroenterology. Pavilion's priority is to provide convenient, cost-effective, and high-quality surgical care in a comfortable and professional atmosphere.

We know that undergoing any type of surgery or procedure can be overwhelming. We believe that the more you are informed the more confident and relaxed you will be during your procedure. Enclosed is information that will assist in making your stay more satisfying.

Financial Information

The Pavilion Surgery Center only charges for the use of the facility and for the services of the Certified Registered Nurse Anesthetist (CRNA). As a courtesy, Pavilion Surgery Center will file health insurance claims. This service does not relieve the patient of any responsibility to pay the Pavilion Surgery Center for services rendered. This includes services, which, for any reason, are not paid by insurance, government programs or other third party sources. Any self-pay portion of my bill is due upon receipt of a statement. **If you have questions on your bill or need to discuss payment options please call 218-279-6200 and ask to speak to the Business Office.**

The fees and charges for the surgeon, anesthesiologist, pathology, radiology, and any other health care provider or services are charged separately from the Pavilion Surgery Center.

Patient Information

Before Your Surgery

Our Pre-operative nurse will call you approximately one week before your procedure to review your health history, medications and pre-operative instructions. If we fail to reach you by telephone, please call our Pre-operative nurse at: **218-279-6207 during the hours of 8:00 am to 4:00 pm.**

Do not eat or drink anything after midnight before your procedure, unless directed otherwise. This includes water, coffee, mints, gum and tobacco products (chew and snuff). You may brush your teeth or rinse your mouth. **If you eat or drink after midnight, your procedure may be cancelled.**

Please shower or bathe the night before surgery or morning of your procedure to minimize chances of infection.

Please DO NOT shave the surgical area unless instructed by your physician.

If you are taking **Aspirin or NSAIDs (such as Advil, Aleve, Motrin or Ibuprofen)** or blood-thinning medications, including: **Coumadin, Plavix, Ticlid, Persantine and Agrenox**, please consult your physician. You **MAY** be asked to discontinue taking them prior to your procedure.

In most cases, you will be required to undergo a physical exam and some routine lab tests prior to your procedure. Your physician's office can help arrange this for you, or you can call the Pavilion Surgery Center for assistance.

Please arrange prior to your procedure: A responsible adult MUST be present to accompany you home and to care for you following surgery. If you do not have someone to drive you home, your procedure may need to be rescheduled until arrangments can be made. Under no circumstances will you be allowed to operate a motor vehicle or machinary if you have received sedation or general anethesia.

Day of Surgery

Please bring your insurance card(s) with you as well as a photo ID (for example a driver's license, state or student ID card). If you do not have a photo ID and/or proof of insurance when you register, your procedure may be postponed or cancelled.

- ***We require at least one parent/guardian be present***, and remain within the facility, at all times during your child's stay.

If you are the Legal Guardian, you will be asked to provide legal documentation

Wear loose casual clothing. Please remove all body piercings, leave your jewelry and valuables at home. If you wear glasses, contact lenses, hearing aids or dentures, bring a case for their safekeeping.

Bring a list of the medications you are currently taking and their dosage. On the morning of your procedure take your usual medications to treat your heart or blood pressure, with a sip of water.

Children may bring their favorite comfort item with them.

Please limit visitors (our pre/post-operative rooms have limited space).

After Your Surgery

You will be discharged to your car. Parking is available near the surgery center.

Your physician will provide post-operative instructions regarding your care, diet, rest, exercise and medications. You will be provided with a written summary of these discharge instructions.

Remember, for your safety, you will NOT be allowed to drive yourself home after your surgery and you should not stay at home alone following your procedure. Please plan to have someone drive you to and from Pavilion Surgery Center.

Advanced Directives

It is the policy of the Surgery Center to inform a patient prior to procedure their rights on Advanced Directives, which include; to be informed of a patient right to formulate an Advance Directive, a patient is not required to have an Advance Directive and the policy of the Pavilion Surgery Center in case of an emergency, to resuscitate a patient in order to maintain their vital functions and if necessary transfer the patient to a hospital for further care. In the event of a hospital transfer the Advance Directive form will be sent with the patient. If you would like more information about Advance Directives, please contact your health care provider, your attorney, or Minnesota Board on Aging's Senior Link Age Line 1-800-333-2433.

Physician Ownership Disclosure

Your surgeon may have a financial interest in Pavilion Surgery Center. If your surgeon has a financial interest in the center it will be posted in the lobby. You may also request this information by calling the center at 218-279-6200.

THE FOLLOWING PHYSICIANS (EMPLOYED BY ST. LUKE'S HOSPITAL) HAVE A FINANCIAL INTEREST IN PAVILION SURGERY CENTER:

WALDO AVELLO, MD
REBEKAH BEACH, MD
ANDREA BENSON, MD
JOHN BOLLINS, DO
NORMAN BOUCHER, MD
JENNIFER BOYLE, MD
JARROD BURESH, DO
STACY COFFIN, MD
MARK EGINTON, MD
TODD FREEMAN, MD
SUSAN GOLTZ, MD
DAVID C. HANSON, MD
BRADLY IRWIN, MD
ELIZABETH JOHNSON, MD
JASON JOHNSON, MD
RICHARD JOHNSON, MD
JOSHUA LARSON, MD
CLAIRE MALLOF, MD
JOSEPH MARTINELLI, MD
DIANE MCCAFFREY, MD
BRIAN MIDBOE, MD
MAX MIRANDA, MD
MARK MONTE, MD
JOHN MORRISON, MD
ANDREW NISBET, MD
DANIEL OPHEIM, MD
ELISABETH REVOIR, MD
JEFFREY SPEER, MD
MICHAEL STELLMAKER, MD
KATHRYN THOMPSON, MD
JENNIFER WITT, MD

THE FOLLOWING INDEPENDENT PHYSICIANS HAVE A FINANCIAL INTERST IN PAVILION SURGERY CENTER:

RAMI GUIRGUIS, DDS
KURTIS KRISTESEN, DPM
GLENN MEINTS, DPM

Directions For your convenience a map of Pavilion Surgery Center is included later in this pack.

Pavilion Surgery Center

920 East First Street, Duluth, MN 55805
(218) 279-6200

Patient Bill of Rights/Patient Rights and Responsibilities

Legislative intent. It is the intent of the legislature and the purpose of this section to promote the interests and wellbeing of the patients and residents of health care facilities. No health care facility may require a patient or resident to waive these rights as a condition of admission to the facility. Any guardian or conservator of a patient or resident or, in the absence of a guardian or conservator, an interested person, may seek enforcement of these rights on behalf of a patient or resident. An interested person may also seek enforcement of these rights on behalf of a patient or resident who has a guardian or conservator through administrative agencies or in district court having jurisdiction over guardianships and conservatorships. Pending the outcome of an enforcement preceding the health care facility may, in good faith, comply with the instructions of a guardian or conservator. It is the intent of this section that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights.

Definitions. For the purposes of this statement, "patient" a person who receives health care services at an outpatient surgical center.

1. Information about rights.
Patients shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. Reasonable accommodations shall be made for those with communication

2. Impairments and those who speak a language other than English.
Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, their guardians or their chosen representatives upon reasonable request to the Administrative Director or other designated staff person.

3. Courteous treatment.
Patients have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.

4. Appropriate health care.
Patients shall have the right to appropriate medical and personal care based on individual needs.

5. Participation in Planning Treatment
Patients shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative, or both. In the event the patient cannot be present, a family member or other representative chosen by the patient may be included in such conferences. A chosen representative may include a doula of the patient's choice.

6. Physician's identity.
Patients shall have or be given, in writing, the name, business address, telephone number, and specialty, if any, of the physician responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the attending physician in a patient's care record, the information shall be given to the patient's guardian or other person designated by the patient as a representative.

7. Relationship with other health services.
Patients who receive services from an outside provider are entitled, upon request, to be told the identity of the provider. Information shall include the name of the outside provider, the address, and a description of the service which may be rendered. In cases where it is medically inadvisable, as documented by the attending physician in a patient's care record, the information shall be given to the patient's guardian or other person designated by the patient as a representative.

8. Information about treatment.
Patients shall be given by their physicians' complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the patients can reasonably be expected to understand. Patients may be accompanied by a family member or other chosen representative. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a patient's medical record, the information shall be given to the patient's guardian or other person designated by the patient or resident as a representative. Individuals have the right to refuse this information. Every patient suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.

9. Right to refuse care.
Competent patients shall have the right to refuse treatment based on the information required in 8. In cases where a patient is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the patient's medical record.

10. Experimental research.
Written, informed consent must be obtained prior to a patient's participation in experimental research. Patients have the right to refuse participation. Both consent and refusal shall be documented in the individual care record.

11. Treatment privacy.
Patients shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient safety or assistance.

12. Confidentiality of records.
Patients shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law

13. Responsive service. Patients shall have the right to a prompt and reasonable response to their questions and requests.

14. Personal privacy.
Patients shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Facility staff shall respect the privacy of a resident's room by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable.

15. Grievances. Patients shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients and citizens. Patients may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Inquiries or complaints regarding medical treatment or the Patients' Bill of Rights/Patient Rights and Responsibilities may be directed to:

Pavilion Surgery Center, LLC

Esther Lindeman, Administrative Director

Terry Ross, Nurse Manager

Minnesota Department of Health
Office of Health Facility Complaints
P.O. Box 64970
St. Paul, MN 55164-0970
218-279-6200 or 218-279-6205 Fax
(651) 201-4201 or 1-800- 369-7994
(651) 201-4202 Fax
health.ohfc-complaints@state.mn.us

Ombudsman for Older Minnesotans
PO Box 64971
St. Paul, MN 55164-0971
(651) 431-2555 or 1-800-657-3591
(651) 431-7452 Fax

Office of the Medicare Beneficiary Ombudsman:
7500 Security Boulevard
Baltimore, MD 21244-1850
1-800-633-4227
TTY 1-877-486-2048
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

NOTICE OF PRIVACY PRACTICES
Effective April 3, 2003

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

Our Responsibilities:

We are required by law to maintain the privacy of your health information and provide you a description or our privacy practices. We will abide by the terms of this notice and notify you if we cannot agree to a requested restriction.

USES & DISCLOSURES OF YOUR HEALTH INFORMATION

The following categories describe examples of the way we use and disclose medical information:

Treatment: The doctors, nurses and other staff of the Pavilion Surgery Center will use your health information to determine the medical care, tests, procedures and medications you may need. We may disclose your health information to coordinate or manage your health care. For example, we may disclose your information to another health care provider to order a referral, prescriptions, lab work or an X-ray for you.

Appointment reminders and other contacts: We may use your health information to contact you with reminders about your appointments, alternative treatments you may want to consider, or other of our services that may be of interest to you.

Payment: We will use your health information to check your eligibility for insurance coverage and prepare a bill to send to you or your insurance company. We will disclose your health information to others to bill and collect payment for our services. For example, in order to bill an insurance company, we will have to disclose information about when you were treated, the conditions you were treated for, and the type of treatment you received.

Health care operations: We may use and disclose your health information to allow us to perform functions necessary for our business of health care. For example, within our organization, we may use your information to help us train new staff and conduct quality improvement activities. We may disclose your information to consultants and other business associates who help us with billing, computer and transcription services. In limited situations, we may disclose information to allow other health care organizations to perform their health care operations. For example, we may disclose your information to your insurance company to allow them to conduct quality improvement activities.

Persons involved in your care: If you are present, we may disclose your health information to a relative or other person involved in your treatment or payment for your treatment, but only if you have had an opportunity to agree or object to that disclosure. For example, you may indicate that you don't mind us disclosing your information to a friend or family member by allowing them to join in your meeting with your doctor. If you are not present to agree or object, we will use our professional judgment to determine if disclosing your health information is in your best interests.

Research: We may use or disclose your health information for research purposes if a review board has determined that your privacy will be appropriately protected.

Required by law: We may also use and disclose health information for the following types of entities including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability.
- Correctional Institutions
- Workers Compensation Agents
- Health Oversight Agencies, such as Medicare and Medical Assistance.
- Medical Examiners and Funeral Directors
- National Security and Intelligence Agencies

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a court order or search warrant.

YOUR HEALTH INFORMATION RIGHTS:

You have several important rights with regard to your health information. The following explains those rights and how you may exercise them.

Right to inspect and copy: You have the right to inspect and copy your health information. We ask that you submit your request to inspect or copy in writing. We may charge you a reasonable fee. In some limited circumstances, we may deny your request to inspect or copy your information. If that happens, you may ask that the denial be reconsidered. Your request and the denial will then be reviewed by a different licensed health care professional – not the one who originally denied your request. We will comply with the decision that professional makes.

Right to request amendment: If you believe that health information we have about you is incorrect or incomplete, you may ask us in writing to amend the information. You must explain the reasons for your request. We may deny your request if the information you are asking us to change:

- Was not created by us (unless the person that created the Information is no longer available to make the amendment);
- Is not part of the health information kept by or for us;
- Is not part of the information you are permitted to inspect and copy; or
- Is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us. Your statement will be included in any disclosures of your information we make in the future.

Right to request restrictions on uses and disclosures of your health information: You have the right to ask us to limit how we use and disclose your health information for your treatment or our payment and business operations purposes. You may also ask that we not disclose your health information to family members or friends involved in your treatment or payment for your treatment. We are not required to agree to your request for a restriction. However, if we do agree, we will comply with our agreement unless there is an emergency or we are otherwise required to use or disclose the information.

Right to request confidential communications from us:
You have the right to ask us to communicate with you about health matters in a specific way or at a specific location. For example, you may ask that we only contact you at work or by mail. We ask that you make your request for confidential communication in writing. We will comply with reasonable requests.

Right to receive an accounting of certain disclosures of your health information we have made: You have the right to request accounting disclosures that occurred after April 13, 2003. This list will not include disclosures made for treatment, payment or healthcare operations. Other uses and disclosures of your health information not covered in this Notice will be made only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your information for the purposes covered by your authorization. You must understand, however, that we are unable to take back any disclosures we have already made in reliance on your authorization.
This Notice will remain in effect until we revise it. We reserve the right to change our privacy practices and the terms of this Notice. Any changes we make will apply to all of the health information about you we maintain. We will make you aware of any changes by:

- Posting the revised Notice in our office;
- Making copies of the revised Notice available upon your request (either at our office

Right to receive a copy of this Notice: You have the right to receive a paper copy of this Notice, even if you have agreed to receive it electronically.

To exercise any of these rights, please contact the Pavilion Surgery Center's Privacy Officer:

Esther Lindeman
Administrative Director
920 East First Street, Suite P-101
Duluth, MN 55805
(218) 279-6200

You may also call or send a written complaint directly to the following:

Office of Health Facility Complaints
(651) 201-4201
1-800- 369-7994
Fax: (651) 281-9796| 800-369-7994

Mailing Address:
Minnesota Department of Health
Office of Health Facility Complaints
85 East Seventh Place, Suite 300
PO Box 64970
St. Paul, MN 55164-0970

Ombudsman for Long-Term Care
MN board on Aging
(651) 431-2555
218-729-1303
Fax: 218-729-1302

Mailing Address:
Ombudsman for Long-Term Care
PO Box 117
Duluth, MN 55801
St. Paul, MN 55164-0971

PAVILION SURGERY CENTER

PLEASE COMPLETE THIS FORM
PRIOR TO YOUR DATE OF PROCEDURE.

YOU MUST **BRING THIS FORM WITH YOU** ON YOUR DATE OF PROCEDURE.

NOTIFICATION TO PATIENTS

Please read the following Statements.
Then place your initials after each statement

Patients Rights and Responsibilities:

- I have been informed of my Patient Rights and Responsibilities. _____

Privacy Practices:

- I have received a copy of Pavilion Surgery Center's Notice of Privacy Practices. _____

Disclosure of Ownership Information

- I have received a copy of the List of Pavilion Surgery Center physician owners. _____

Advance Directives:

- I have been informed of my rights to formulate an Advance Directive **(Living Will)** and I understand that I am not required to have an Advance Directive in order to receive medical treatment at Pavilion Surgery Center. _____
- I understand that it is the policy of Pavilion Surgery Center to resuscitate all patients that require resuscitation in order to maintain their vital functions. _____
- I understand that in the case of a medical emergency that I may be transferred to St. Luke's Hospital. _____
- Please check the following statement that applies in the event of a hospital transfer:
  - _____ **I have** formulated an Advance Directive (Living Will) and brought it today.
  - _____ **I have** formulated an Advance Directive (Living Will) but did NOT bring it today.
  - _____ **I have not** formulated an Advance Directive (Living Will) and DO NOT want a form.
  - _____ **I have not** formulated an Advance Directive (Living Will) but want a form today.

Statement of Compliance

If I am having any form of conscious sedation, spinal or general anesthesia I certify that I have a responsible adult driver to take me home after my procedure. I understand that if I do not have a driver, my procedure may be cancelled. Please provide the driver's name and telephone number. You should also make arrangements to have someone stay with you following your procedure. I have also been advised not to operate a motor vehicle or any machinery for at least 24 hours after my procedure if I have received sedation or general anesthesia.

_____ Name of Driver (Please Print)

_____ Driver's Telephone #

I have read and understand the above information.
(Please sign and Date this form)

_____ Signature of Patient or Patient Representative

_____ Relationship to Patient

_____ Date

_____ Signature of Verifying PSC Employee

_____ Date

_____ Time

PAVILION SURGERY CENTER

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YOU MUST **BRING THIS FORM WITH YOU**
ON YOUR DATE OF PROCEDURE.

AUTHORIZATION FORM

A. CONSENT FOR TREATMENT

I present myself for health care services at Pavilion Surgery Center, to be provided by authorized employees and medical staff of the surgery center. I authorize these individuals to provide services that, in their professional judgment, are deemed necessary and/or beneficial. I realize that, unless requested otherwise, in addition to the above employees and medical staff, medical residents, medical students and/or surgical/medical device manufacturers may be present during the provision of my patient care services. The medical residents and/or medical students are under the direct supervision of the performing surgeon. I acknowledge that Pavilion Surgery Center and St. Luke's may share my health information to facilitate my care and assist in the coordination of my care.

B. BLOOD TESTING

If a health care worker is exposed to my blood or body fluids through a needle stick, cut, or splash to the eye or mouth, I agree to have my blood drawn and tested for blood-borne diseases to include Hepatitis B Virus, Hepatitis C Virus, and Human Immunodeficiency Virus (HIV). I authorize the release of these test results to the Employee Health Services at St Luke's Hospital as well as the exposed person. I understand the results will become a part of my medical record. If test results are positive, state law mandates reporting to the MN Department of Health.

C. ASSIGNMENT OF BENEFITS

I request that payment of authorized benefits for services furnished by Pavilion Surgery Center be made directly to Pavilion Surgery Center, and I assign such benefits to Pavilion Surgery Center. I understand that I am responsible for the costs of non-covered services and for any deductibles, co-insurance, and/or co-payment charges that are allowed under federal regulations or as specified in my particular health insurance policy. I understand that I am responsible for understanding the limitations and exclusions of coverage under my health insurance policy.

D. FINANCIAL AGREEMENT

I agree to pay Pavilion Surgery Center for all services provided to me. As a courtesy, Pavilion Surgery Center will file health insurance claims on my behalf, if provided with accurate and complete health insurance information. This service does not relieve me of any responsibility to pay the Pavilion Surgery Center for services rendered. This includes services, which, for any reason, are not paid by insurance, government programs or other third party sources. I understand that any self-pay portion of my bill is due upon receipt of a statement. **If you have questions on your bill or need to discuss payment options please call 218-279-6200 and ask to speak to the Business Office.** I understand that if payments or payment arrangements are not made, unpaid accounts will be turned over to a collection agency. I further agree to pay reasonable attorney's fees and all costs of collection in the event my account is turned over to an attorney or collection agency.

I understand that the Pavilion Surgery Center only charges for the use of the facility and for the services of the Certified Registered Nurse Anesthetist (CRNA). I understand that the fees and charges for the surgeon, anesthesiologist, pathology, radiology, and any other health care provider or services are charged separately from the Pavilion Surgery Center charges and that the Pavilion Surgery Center has no control over those charges or fees.

I have read and understand these authorizations. **(Please Sign and Date this form)**

Signature of Patient or Patient Representative	Relationship to Patient	Date

Signature of Verifying PSC Employee	Date	Time