DISC SURGERY CENTER AT THOUSAND OAKS
Surgical Center Demographics

DATE	LAST NAME	FIRST NAME	M.I.	PHYSICIAN NAME	PATIENT NUMBER

M/F	D.O.B.	AGE	M S W	SSN	HOME #	CELL #	WORK #

ADDRESS: STREET	CITY	STATE	ZIP CODE

EMAIL ADDRESS

EMPLOYER	HR CONTACT	PHONE

EMERGENCY CONTACT	EMERGENCY CONTACT PHONE	EMERGENCY CONTACT RELATION

PRIMARY INS.CO.NAME		SECONDARY INS.CO.NAME	
INS.CO. ADDRESS		INS.CO. ADDRESS	
ID# / CLAIM#	GROUP#	ID# / CLAIM#	GROUP#

SUBSCRIBER NAME (IF DIFFERENT FROM ABOVE)	SUBSCRIBER D.O.B.	SUBSCRIBER PHONE#	SUBSCRIBER SSN

CLAIM NUMBER	ADJUSTOR NAME	ADJUSTOR PHONE#	D.O.I.

DIAGNOSIS

PROPOSED SURGERY (LINE 1)

PROPOSED SURGERY (LINE 2)

PAYMENT REQUIRED	AMOUNT PAID	BALANCE DUE	RECEIPT

CONSENT TO DRAW BLOOD/EMERGENCY PROCEDURES

I hereby consent to the withdrawal of a blood sample in the event an employee or contractor of the Surgery Center has a needle stick or mucous membrane exposure to my blood or body fluids. I further consent to a medical treatment from a licensed physician in the event of a highly emergent or emergency event in which the patient, a family member or other responsible party cannot reasonably be reached to authorize treatment.

RELEASE OF INFORMATION

In general, the Surgery Center, its personnel and members of its Medical Staff treat medical information concerning the patient's procedure as confidential. I authorize the Surgery Center to release any information necessary for the purpose of determining coverage to my insurer or other entity responsible for claims payments without my further written consent.

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FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS

In consideration for the services rendered to the above-named patient, the undersigned hereby individually obligates himself/herself to the account of the Surgery Center in accordance with the Surgery Center's regular rates and terms regardless of whether insurance payments are available or made on my behalf. In the event it should be necessary to refer the account to any attorney or collection agency for collection, I hereby agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts, at the Surgery Center's option, will bear interest at the legal rate.

In consideration of services rendered to the above-named patient, the undersigned hereby authorizes direct payment of any insurance benefits to the above-named Surgery Center otherwise payable to me for this admission. I transfer and assign all rights, title and interest in the above-named insurance policy any payment due me to the above-named Surgery Center. I understand and agree that I am responsible for providing any information required by my insurance company and agree to follow those pre-admission and pre-authorization guidelines, which the insurance company may require. I understand that I am financially responsible for all charges which are not covered by insurance, including but not limited to, co-pays, deductibles, and charges in excess of policy coverage, and limitations or exclusive of coverage.

PERSONAL VALUABLES AND MEDICATIONS

It is understood and agreed that the Surgery Center will not be liable for any loss or damages to valuables, including but not limited to, money, jewelry, glasses, dentures, for items, documents, canes or personal medical equipment or supplies, clothing, shoes or other apparel. It is understood and agreed that I will not bring or consume personal medications without the Surgery Center's notice of written permission from my attending physician and that the Surgery Center will not be liable for any harm incurred thereby.

ADVANCE HEALTHCARE DIRECTIVES

I understand that the Surgery Center has not consented to honor an Advance Healthcare Directive and will not be liable for its terms. Upon my request, the Surgery Center will provide information to me regarding alternate facilities that I may use.

_____ I understand that I am not required to have an Advanced Healthcare Directive in order to receive medical treatment in this Surgery Center

_____ I have not executed an Advance Healthcare Directive.

_____ I understand that I will be resuscitated and transferred to a hospital where my Advance Healthcare Directive and/or DNR may be honored.

PHYSICIAN

In consideration of medical or surgical services rendered to the above-named patient, the undersigned hereby authorizes direct payment of any insurance benefits due to me, to the physician named above, as well as, if required, the Assistant Physician and/or Anesthesiologist . I transfer all rights, title, and interest in the above-named insurance policy, any payment due for physician medical/surgical services to:

Physician _____ Assistant Physician _____

Anesthesia _____

Your physician may or may not be an investor in the Surgery Center. Please contact your physician if you desire further information. Diagnostic and Interventional Surgical Center's Staff will provide you with a complete list of the physician owners of this facility upon request.

I certify that I have read the foregoing and that I am either the patient, parent, legal guardian, or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

I understand and agree that, at the time the patient has met the Surgery Center's medical criteria to leave the Center, I will have a responsible adult present to take me/the patient home if I (he/she) have (has) received anesthesia/sedation. I release the Surgery Center from any responsibility for events in violation of this agreement.

_____	_____	_____	_____AM/PM
Patient Signature	Witness Signature	Date	Time

_____	_____
Patient Representative	Relationship to Patient

DISC SURGERY CENTER AT THOUSAND OAKS
Appeal Authorization and Insurance Payment Agreement

Patient Name: _____ DOB: _____

Insurance Company: _____

ID # _____

Date of Service: _____

Per my insurance company, the payment for services provided to me by DISC Surgery Center at Thousand Oaks on the date above may be mailed to me, the member.

I agree to endorse and forward all checks I receive from my insurance carrier to DISC Surgery Center at Thousand Oaks as payment for the services provided to me by them.

If I fail to do this once the claim has been processed, I agree to pay the full invoice amount to DISC Surgery Center at Thousand Oaks.

I will be responsible for any deductible amount applied to my charges by my insurance company.

In the event that my insurance company denies or low pays any medical services performed, I (_____) hereby authorize DISC Surgery Center at Thousand Oaks to file an appeal on my behalf.

Should my insurance company fail to pay at the reasonable and customary rate or deny payment for services, I understand that I will be financially responsible for the invoice amount.

Thank you,

_____ _____
PATIENT SIGNATURE DATE SIGNED

Revised 06/2024

Our Ethics, Rights & Responsibilities

The surgery center has adopted the following list of rights & responsibilities for patients: *The facility will observe and respect a patient's rights and responsibilities without regard to age, race, color, sex, national origin, religion, culture, physical or mental disability, gender identity, personal values, or belief systems. The facility will, prior to the start of the surgical procedure, provide the patient, the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights*

Patient Rights: *The patient has the right to:*

- Considerate, respectful, and dignified care and respect for personal values, beliefs, and preferences.
- Access to treatment without regard to race, ethnicity, national origin, color, creed/religion, sex, gender identity, age, mental disability, or physical disability. Any treatment determinations based on a person's physical status or diagnosis will be made based on medical evidence and treatment capability.
- Respect of personal privacy throughout entire facility.
- Receive care in a safe and secure environment and follow the agreed-upon treatment plan prescribed by their provider and be an active participant in their care.
- Exercise your rights without being subjected to discrimination or reprisal.
- Know the identity of persons providing care, treatment, or services and, upon request, be informed of the credentials of healthcare providers and, if applicable, the lack of malpractice coverage.
- Expect the center to disclose, when applicable, physician financial interests or ownership in the center.
- Receive assistance when requesting a change in primary or specialty physicians, dentists, or anesthesia providers if other qualified physicians, dentists, or anesthesia providers are available.
- Receive information concerning your diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information, the information is provided to a person designated by the patient or to a legally authorized person.
- Receive information about unanticipated outcomes of care.
- Receive information from the physician about any proposed treatment or procedure as needed to give or withhold informed consent.
- Participate in decisions about their health care, treatment or services planned and to refuse care, treatment, or services, in accordance with law and regulation, except when such participation is contraindicated for medical reasons.
- Be informed, or when appropriate, your representative be informed (as allowed under state law) of your rights in advance of furnishing or discontinuing patient care whenever possible.
- Receive information in a manner tailored to your level of understanding, including provision of interpretative assistance or assistive devices.
- Have family be involved in care, treatment, or services decisions to the extent permitted by the patient or your surrogate decision maker, in accordance with laws and regulations.
- Appropriate assessment and management of pain, information about pain, pain relief measures and participation in pain management decisions.
- Give or withhold informed consent to produce or use recordings, film, or other images for purposes other than care, and to request cessation of production of the recordings, films, or other images at any time.
- Be informed of and permit or refuse any human experimentation or other research/educational projects affecting care or treatment.
- Confidentiality of all information pertaining to care and stay in the center, including medical records and, except as required by law, the right to approve or refuse the release of your medical records.
- Access to and/or copies of your medical records within a reasonable time frame and the ability to request amendments to your medical records.
- Obtain information on disclosures of health information within a reasonable time frame.
- Have an advance directive, such as a living will or durable power of attorney for healthcare and be informed as to the center's policy regarding advance directives/living will. Expect the center to provide the state's official advance directive form if requested and where applicable.
- Obtain information concerning fees for services rendered and the center's payment policies.
- Be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.
- Be free from all forms of abuse or harassment.

- Expect the center to establish a process for prompt resolution of patients' grievances and to inform each patient whom to contact to file a grievance. Grievances/complaints and suggestions regarding treatment or care that is (or fails to be) furnished may be expressed at any time. Grievances may be lodged with the state agency directly using the contact information provided on the patient rights poster posted in the center lobby.

- If a patient is adjudged incompetent under applicable State laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.
- If a state court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.
- You may request the services of the organization, provisions for after-hours and emergency care, fees for service and payment policies.

Patient Responsibilities: *The Patient is responsible for:*

- Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Behaving respectfully toward all health care professionals and staff, as well as other patients and visitors.
- Identifying any patient safety concerns.
- Observing prescribed rules of the center during your stay and treatment.
- Providing a responsible adult to provide transportation home and to remain with them for 24 hours as if directed by the provider or as indicated on discharge instructions.
- Reporting whether you clearly understand the planned course of treatment and what is expected of you and asking questions when you do not understand their care, treatment, or service or what you are expected to do.
- Keeping appointments and, when unable to do so for any reason, notifying the center and physician.
- Providing complete and accurate information to the best of your ability about your health, any medications taken, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
- Promptly fulfilling your financial obligations to the center, including personal financial responsibilities for any charges not covered by insurance.
- Payment to center for copies of the medical records they may request.
- Informing your providers about any living will, medical power of attorney, or other advance directive that could affect your care.

PROCESS TO EXPRESS & FILE A COMPLAINT: It is the mission of this organization to provide care that we wish for our loved ones & ourselves. We welcome suggestions and complaints, as well as appreciation. Your feedback is important to help us improve patient care and our environment. We will mail you a patient satisfaction form within ten (10) business days after surgery. We hope you take time to complete the survey. You may express your concern or complaint at any time to a staff member or the administrator. The administrator reviews all compliments and complaints and attempts to rectify any issue and will send you a written response within thirty (30) calendar days of the complaint.

Chastity Pryor
DISC Surgery Center at Thousand Oaks
1120 Newbury Road, Ste 100, Thousand Oaks CA 91320

If the issue is not resolved to your satisfaction, the Governing Body will review the complaint. A representative of the Governing Body will contact you, in writing, within thirty (30) calendar days of the complaint. If you are still not satisfied, you may file a written complaint with the California Department of Public Health.

Center for Healthcare Quality, Licensing, and Certification
Division: East Bay District Office
850 Marina Bay Pkwy, Bld P 1st FL, Richmond, CA 94804
(510) 620-3900
OR
AAAHC
5250 Old Orchard Road, Suite 200, Skokie, IL 60077
(847) 853-6060
AND/OR
Medicare & Medicaid Services at:
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

ADVANCED DIRECTIVES: An "Advance Directive" is a general term that refers to your oral and written instructions about your future medical care if you become unable to speak for yourself. Each state regulates the use of advance directives differently. There are two types of advance directives: a living will and a medical power of attorney. If you would like a copy http://www.calhospital.org/public/advancehealth-care-directive

ADVANCE DIRECTIVE POLICY: Most procedures performed at the Surgery Center are of minimal risk. Of course, no surgery is without risk. You and your procedure and the risks associated with your procedure, the expected recovery, and the care after your surgery. It is the policy of the Surgery Center, regardless of the contents of any advance directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at the Surgery Center, the personnel at the Surgery Center will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive, or health care power of attorney. I received information on patient rights, patient responsibilities, physician disclosure, advance directive policy and grievance policy prior to the start of my surgical procedure.

English and Spanish versions of Patient Rights and Responsibilities handout are available.

_____
Patient Signature

_____
Date

CREDIT CARD OVERAGE FORM

CARD HOLDER INFORMATION

VISA MASTERCARD AMEX DISCOVER CHECK

PATIENT NAME_____

CARD #_____

EXPIRATION DATE _____

CARD HOLDER NAME_____

SECURITY CODE_____

OVERAGE TIME: FACILITY_____ ANESTHESIOLOGIST_____

CHARGE AMOUNT FACILITY $_____ ANESTHESIOLOGIST$_____

DATE OF SERVICE_____

PHYSICIAN_____

YOUR CREDIT CARD INFORMATION WILL BE KEPT WITH THOUSAND OAKS SURGERY CENTER (TOSC) UNTIL YOUR PROCEDURE IS COMPLETED. IF YOU'RE PROCEDURE TAKES LONGER THAN EXPECTED YOUR CARD WILL BE CHARGED FOR ANY ADDITIONAL FEES ON THE DATE OF SERVICE. BY SIGNING, YOU AGREE TO ALLOW TOSC TO CHARGE THIS CARD FOR THE ABOVE FEE.

X_____