Roswell Surgery Center
1285 Hembree Road Suite 200C
Roswell, GA 30076
(770) 772-5520 Fax: (770) 772-5521

PATIENT RIGHTS

- Receive access to equal medical treatment and accommodations regardless of race, creed, sex, national origin, religion or sources of payment for care.
- Be fully informed and have complete information, to the extent known by the physician, regarding diagnosis, treatment, procedure and prognosis, as well as the risks and side effects associated with treatment and procedure prior to the procedure.
- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice grievances regarding treatment or care that is (or fails to be) furnished.
- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.
- Receive the care necessary to regain or maintain his or her maximum state of health and if necessary, cope with death.
- Know the identity of persons providing care, treatment or services and, upon request, be informed of the credentials of healthcare providers.
- Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience, as well as perform the services for which they are responsible with the highest quality of services.
- Be fully informed of the scope of services available at the facility, provisions for after-hours care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.
- Make informed decisions regarding his or her care.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, or as required by law or third party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care of treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time.
- Access to and/or copies of his/her medical records.
- Be informed as to the facility's policy regarding advance directives/living wills.
- Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the patient transfer.
- Express those spiritual beliefs and cultural practices that do not harm or interfere with the planned course of medical therapy for the patient.
- Expect the facility to agree to comply with Federal Civil Rights Laws that assure it will provide interpretation for individuals who are not proficient in English.
- Have an assessment and regular assessment of pain.
- Education of patients and families, when appropriate, regarding their roles in managing pain.
- To change providers if other qualified providers are available.

If a patient is adjudged incompetent under applicable state health and safety 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 designated by the patient in accordance with state laws may exercise the patient's rights to the extent allowed by state law.

PATIENT RESPONSIBILITIES

- Be considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the facility.
- Be respectful of all the health care professionals and staff, as well as other patients.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.
- Follow the treatment plan prescribed by his/her provider and participate in his/her care.
- Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.
- Providing care givers with the most accurate, honest, and complete information to the best of his/her ability regarding present complaints, symptoms, past illnesses procedures and hospitalizations, any medications including over-the-counter products and dietary supplements, and any allergies or sensitivities, unexpected changes in the patient's condition or any other patient health matters.

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- Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting to care at the facility.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Provide payment to center for any copies of medical records that he/she may request.
- Identifying any patient safety concerns.
- Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider.

PATIENT COMPLAINT OR GRIEVANCE

If you should have a concern or complaint regarding any services, treatment or care that is or fails to be rendered at our Center, please let us know while you are here so that we may have the opportunity to improve. You may also contact the facility Administrator by phone at (770) 772-5520, or by mail:

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Complaints and grievances may also be filed through the:
State of Georgia, Department of Community Health
Healthcare Facility Regulation Division
Attn: Complaint Intake Unit
2 Peachtree St., NW, Suite 31-447
Atlanta, GA 30303-3142
Fax: (404) 657-5731
Main: 1-800-878-6442

AAAHC-Accreditation Association for Ambulatory Health Care
Email: info@aaahc.org
Website: http://www.aaahc.org
Phone: 847-853-6060

For Medicare beneficiaries:
Georgia Medicare Part B
P. O. Box 12967
Birmingham, AL 35202

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Call 1-800-633-4227 or visit the Ombudsman's webpage on the web at:

https://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

ADVANCE DIRECTIVE NOTIFICATION

In the State of Georgia, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to make decisions or unable to communicate decisions. Roswell Surgery Center respects and upholds those rights.

However, unlike in an acute care hospital setting, Roswell Surgery Center does not routinely perform "high risk" procedures. While no surgery is without risk, most procedures performed in this facility are considered to be of minimal risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after your surgery.

Therefore, it is our policy, 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 the your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or health care Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you wish to complete an Advance Directive, copies of the official State forms are available at our facility.

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

DISCLOSURE OF OWNERSHIP

Roswell Surgery Center is proud to have a number of quality physicians invested in our facility. Their investment enables them to have a voice in the administration of policies of our facility. This involvement helps to ensure the highest quality of surgical care for our patients. Your physician **does** have a financial interest in this facility.

By signing this document, I acknowledge that I have read and understand its contents:

Patient/Patient Representative Signature Date