To all of our patients,

We have several forms attached with information for you to review prior to your procedure at our center. You will find a complete listing of your rights and responsibilities, our privacy notice, advance directives and our policy on advance directives, a complete list of ownership in our facility and a brochure which tells you what to expect and has a map on the back of the location you will be having your procedure at.

The top page is an **acknowledgement sheet that we will need signed prior to your procedure and brought with you on your date of service.** This is acknowledging we have given you the above. **Please also complete the Demographic form and bring it to the surgery center with you on the day of your procedure along with your insurance card and picture ID.**

Thank you for choosing our center to have your procedure. We take pride in giving our patients the best possible care and welcome any suggestions you may have.

Sincerely,

The Management Team
The Surgery Center of Carmel (317) 569-8250

The Surgery Center of Carmel, LLC

ACKNOWLEDGEMENT

I acknowledge I have received a copy of my Right and Responsibilities, Advance Directives, the center's policy on Advance Directives, a listing of Physician ownership and our center's Privacy Notice. I also acknowledge that I was verbally notified of this information prior to my surgery.

_____ _____

Patient or Personal Representative Signature Date

_____

Personal Representative's Relation to Patient

DOCUMENTATION OF GOOD FAITH EFFORT

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

- o Patient refused to sign the Privacy Notice Acknowledgement
- o Patient was unable to sign because:_____
- o There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.
- o Other reason, described below:

_____

_____ _____

Employee Signature Date

THE SURGERY CENTER *of* CARMEL
Patient Demographics

PATIENT INFORMATION

PATIENT NAME: _____ SOCIAL SECURITY #: _____

DOB: ___/___/___ SEX: ☐ M ☐ F MARITAL STATUS: ☐ single ☐ married ☐ divorced ☐ widowed

RACE: _____ LANGUAGE: _____

HOME PHONE: (_____) _____ ALTERNATE PHONE: (_____) _____

ADDRESS: _____
street *city/state* *zip*

EMAIL ADDRESS: _____

PATIENT EMPLOYER: _____ WORK PHONE: (_____) _____

WORK ADDRESS: _____
street *city/state* *zip*

OCCUPATION: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____
street *city/state* *zip*

HOME PHONE: (_____) _____ OTHER PHONE: (_____) _____

INSURANCE INFORMATION

SUBSCRIBER NAME: _____ DOB: ___/___/___

SOCIAL SECURITY #: _____ DRIVER's LICENSE #: _____

ID/POLICY #: _____ GROUP #: _____

BILLING ADDRESS: _____

CUSTOMER SERVICE PHONE: (_____) _____

EMPLOYER: _____ WORK PHONE: (_____) _____

EMPLOYER ADDRESS: _____
street *city/state* *zip*

OCCUPATION: _____

FOR WORKMAN'S COMPENSATION CLAIMS ONLY

CASE #: _____ CASE MANAGER'S NAME: _____

PHONE #: (_____) _____ IS THIS APPROVED: ☐ Y ☐ N

CLAIMS ADDRESS: _____
street *city/state* *zip*

Financial Agreement: If you have insurance, we will help you receive maximum benefits by filing your claims for you. The undersigned further agrees that all charges incurred relating to the collection of delinquent accounts will be borne by the patient/guarantor.

Assignment of Benefits: I hereby assign all my insurance benefits under the described policies and authorize SCC, St Vincent Health and NAS to bill for charges incurred and to provide any medical information necessary to process this claim. I authorize payment to be made directly to SCC, St Vincent Health and NAS.

Release of Information: I, the undersigned, authorize the SCC and/or St Vincent Hospital Services to release all or part of my medical records when required for the submission of insurance claims or the operation of the Center. SCC, its agents, servants and employees are hereby released from any and all liability of any nature that may arise from the release of such information.

Medicare Part B Signature Authorization Release of Information and Payment Request: Medicare patient-I certify that the information given by me in applying for payment under TITLE XVII OF THE Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I request payment under the medical insurance program to be made either to me or SCC to inquire about and receive any information about any and all of my Medicare Part B claims, assigned and/or assigned.

Separate Billing: You will receive a separate statement from your physician for his services at The Surgery Center of Carmel. In addition, if you require anesthesia, the contracted anesthesia group will send you a statement for their services. If your physician orders pathology or blood work while at the Surgery Center the laboratory could bill you directly for their services.

Property Release: The Surgery Center of Carmel will make every effort to protect your possessions while you are under out care. Please leave valuables with your family or friends. I understand that SCC cannot be held responsible for the loss or damage of my personal property.

Certification: I certify that the information given above is correct. The undersigned certifies that they are the patient or are duly authorized by the patient to execute this document and accept its terms. The undersigned certifies that he/she has read and understand the foregoing and fully accepts the terms specified above. A photo static copy of this agreement shall be considered as effective and valid as the original.

X_____ **X**_____ **X**_____

Signature of Patient or Guarantor | Relationship to Patient | Date

X_____ **X**_____

Witness Signature | Date

The Surgery Center of Carmel

SURGICAL HOME MEDICATION RECONCILIATION FOR

☐ No Home Medications/supplements

Pre-op RN signature: ____________________________**Date:**_______________

Allergy______________________ Reaction_____________ **Allergy**________________ Reaction_________________________

____

☐ **NKDA** ☐ **NKA**

Current Medications Herbal Supplements	DOSE	Route PO	Frequency	Date last taken			Continue after discharge/MD
			daily twice a day as needed three times a day at bedtime				☐ YES ☐NO
			daily twice a day as needed three times a day at bedtime				☐ YES ☐NO
			daily twice a day as needed three times a day at bedtime				☐ YES ☐NO
			daily twice a day as needed three times a day at bedtime				☐ YES ☐NO
			daily twice a day as needed three times a day at bedtime				☐ YES ☐NO
			daily twice a day as needed three times a day at bedtime				☐ YES ☐NO
			daily twice a day as needed three times a day at bedtime				☐ YES ☐NO
			daily twice a day as needed three times a day at bedtime				☐ YES ☐NO
			daily twice a day as needed three times a day at bedtime				☐YES ☐ NO
			daily twice a day as needed three times a day at bedtime				☐YES ☐ NO
☐**See attached medication list.**			daily twice a day as needed three times a day at bedtime				☐YES ☐ NO

☐ **Discharge Medications reviewed with Patient /Family** ☐**Resume all Pre op medications**

DISCHARGE RN SIGNATURE____**DATE**_____________________

ADVANCE DIRECTIVES

An advance directive is a document that pertains to treatment preferences and the designation of a surrogate decision-maker in the event that a person should become unable to make medical decisions on their own behalf. Advance directives are generally in the form of a living will, life-prolonging procedures declaration, designation of a health care representative or proxy and durable power-of-attorney. Advance directives can be revoked or amended at any time. This section on advance directives has been designed to help you understand Federal and Indiana laws about advance directives and The Surgery Center's policies about these issues.

Federal Law

The 1990 Patient Self-Determination Act is a federal law that says patients must be informed of their rights under state law to make decisions about their medical care, including the right to accept or refuse medical or surgical treatment and the right to have an advanced directive. The advance directive document is a way for you to communicate what kinds of medical care and treatment you do or do not want if you become unable to make these decisions for yourself.

Indiana Law

According to Indiana law, "competent adults have the right to control the decisions relating to their own medical care, including the decision to have medical or surgical means or procedures intended to prolong their lives, provided, withheld or withdraw.

Under Indiana law, a written advance directive can communicate a competent person's wishes regarding health care, including life-prolonging treatment. The directive can designate a person who will have the role of making difficult health care decisions for you, if you become unable to state your wishes. A formal advance directive can be in the form of a living will, a life-prolonging procedures declaration, an appointment of a health care representative or an appointment of a power-of-attorney for health care (Indiana Code IC 16-8-11). You have a right to make an advance directive if you want to, but you are not required to do so.

Living Will

A living will is an advance directive that allows you to specify or limit the kinds of life-prolonging procedures you wish to receive if you become terminally ill and unable to make medical decisions. It is a voluntary executed document put into writing and signed by the person making the declaration (or his/her representative if the patient is unable to sign) and signed in the presence of at least two witnesses.

Life-Prolonging Procedures Declaration

A life-prolonging procedures declaration document is an advance directive that allows you to specify your wish to receive life-prolonging procedures that would extend life if you become terminally ill and unable to make medical decisions. This declaration must be signed and dated and witnessed by two people who are at least 18 years old and who know you well but are not related to you. These witnesses should not be your potential heirs or your health care providers and they should not hold direct financial responsibility for your health care.

Health Care Representative

A health care representative document is an advance directive that allows you to name someone else to make your health care decisions for you should you become unable to make health care decisions. You should tell this person of your wishes about refusing or stopping care, as well as matters of more routine care. This type of advance directive can relate to any medical situation, not just terminal illness.

Power of Attorney for Health Care

A power-of-attorney for health care document is another advance directive that allows you to name someone else to make your health care decisions for you if you become unable to make your own health care decisions. Instruction about treatment preferred or treatment to be avoided can also be included. This type of advance directive relates to any medical situation, not just terminal illness.

Advance Directive Policies at The Surgery Center of Indianapolis, LLC.

Compliance with the 1990 Patient Self-Determination Act is intended for inpatient hospital admissions, not for outpatient surgery centers. The Surgery Center of Indianapolis, LLC. does not honor advance directives. Health care providers at The Surgery Center of Indianapolis, LLC are bound to do all in their power to assure the safe recovery of every patient, including resuscitation if that becomes necessary. All adult patients are asked if they have an advance directive, which is placed in their medical record. Adult patients are also informed that an advance directive will not be honored while a patient at The Surgery Center of Carmel, LLC.

For More Information

Additional information, including sample advance directive forms, can be found online at the following websites:

(advance directives)
http://www/in.gov/isdh/files/advancedirectives.pdf
(living will)
http://iahhc.affiniscape.com/associations/1822/files/LIVING%20WILL%20DECLARATION.pdf
(life-prolonging procedures declaration)
http://iahhc.affinscape.com.associations/1822/files/Life%20Prolonging%20Procedure%20Form.pdf

Patient Rights and Responsibilities

Each patient, or parent or legal guardian of a minor patient, you have a right to:

- Be treated with respect, consideration and dignity
- Respectful care given by competent personnel with consideration of their privacy concerning their medical care.
- Be given the name of their attending physician, the names of all other physicians directly assisting in their care, and the names and functions of other health care persons having direct contact with the patient.
- Have records pertaining to their medical care treated as confidential and, except when reviewed by law, patients are given the opportunity to approve or refuse their release.
- Know what Surgery Center rules and regulations apply to their conduct as a patient.
- Expect emergency procedures to be implemented without necessary delay.
- Expedient and professional transfer to another facility when medically necessary and to have the responsible person and the facility that the patient is transferred to notified prior to transfer.
- Full information in laymen's terms concerning diagnosis and treatment; if it is not medically advisable to give this information to the patient, the information shall be given to the responsible person on his/her behalf.
- Receive a second opinion concerning the proposed surgical procedure, if requested.
- Information on after-hour and emergency care.
- Give an informed consent to the physician prior to the start of a procedure.
- Be advised of participation in a medical research program or donor program; the patient shall give consent prior to participation in such a program that has previously given informed consent to participate in.
- Receive appropriate and timely referrals and consultation.
- Receive appropriate and timely follow-up information of abnormal findings and tests.
- Receive information regarding "continuity of care."
- Refuse drugs or procedures and have a physician explain the medical consequences of the drugs or procedures.
- Medical and nursing services without discrimination based upon age, race, color religion, sex, national origin, handicap, disability, or source of payment.
- Be given the opportunity to participate in discussions involving their healthcare, except when such participation is contraindicated for medical reasons.
- Have access to an interpreter whenever possible.
- Be provided with, upon written request, access to all information contained in their medical record.
- Accurate information regarding the competence and capabilities of the organization.
- Receive information regarding methods of expressing suggestions or grievances to the organization.
- File any complaints/grievances with the administration at The Surgery Center of Indianapolis, LLC and receive an appropriate response within ten (10) business days. Contact information for administration is The Surgery Center of Indianapolis, LLC – Administrator, 12188 A N Meridian #150, Carmel, IN 46032. Telephone number is 317-569-8250.
- Refer complaints or grievances regarding quality of Care, premature discharge, or beneficiary complaints To the Indiana State Department of Health at 317-233-1325; TTY 317-233-5577 or by letter at 2 N Meridian St., Indianapolis, IN 46204, or via web @ www.in.gov/isdh. You may contact the Medicare Beneficiary Ombudsman @www.medicare.gov/Ombudsman/activities.asp, or by calling 1-800-MEDICARE (633-4227).
- Appropriate assessment and management of pain.
- Participate in their own healthcare decisions except if this is contraindicated due to medical reasons.
- Information regarding fees for services and payment policies.
- Be informed of their right to change primary or specialty physicians if other qualified physicians are available.
- Receive a Patient Privacy Notice which provides an explanation of how their protected health information is utilized and to those that may need to receive it.
- A verbal and written notice of these patient rights and responsibilities, receive information pertaining to the facility's policy for advances directives (including a Description of applicable state health and safety laws and if requested, official state advance directive forms), written disclosure of physician financial interests or ownership, **all of which must be provided in advance of the date of service.**
- Receive care in a safe setting and one that is free from all forms of abuse or harassment.

Each patient treated at The Surgery Center of Indianapolis, LLC has the responsibility to:

- Provide the Surgery Center staff with complete, accurate health information, any medications including over-the-counter products, dietary supplements and any allergies or sensitivities.
- Follow instructions given by his/her surgeon, anesthesiologist, and operative care team.
- Provide a responsible adult to transport the patient home from the facility and remain with him/her for 24 hours if required by the physician.
- Provide the Surgery Center with all information regarding third-party insurance coverage.
- Fulfill financial responsibility for all services received as determined by the patient's insurance carrier.
- Be respectful of all healthcare providers, staff, and other patients.
- Inform a facility/staff member regarding any of the following:
    1. If they feel that their privacy has been violated.
    2. If their safety is being threatened.
    3. If they feel a need/desire to file a grievance.

Advance Directive Policies at The Surgery Center of Indianapolis, LLC

Compliance with the 1990 Patient Self-Determination Act is intended for inpatient hospital admissions, nor for outpatient surgery centers. The Surgery Center of Indianapolis, LLC are bound to do all in their power to assure the safe recovery of every patient, including resuscitation if that becomes necessary. All adult patients are asked if they have an advance directive, which is placed in their medical record. Adult patients are also informed that an advance directive will not be honored while a patient at The Surgery Center of Carmel.

The Surgery Center of Carmel
Privacy Notice

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 Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. Your "protected health information" means any written or oral information about you, including demographic data that can be used to identify you, created or received by your health care provider, which relates to your past, present, or future physical or mental health or condition.

Uses and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations

We may use your protected health information for the purposes of providing treatment, obtaining payment for treatment, and conduction health care operations. Your protected health information may be used or disclosed only for these purposes unless we have obtained your authorization or the use or disclosure is permitted or required by the HIPAA regulations or other law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by electronic means.

1. **Treatment.** We will use and disclose your protected healthcare information to provide, coordinate, or manage your health care and related services, including coordination and management with third parties for treatment purposes. Here are some examples of how we may use or disclose your protected health information for treatment:
   a. We may disclose your protected health information to a laboratory to order tests.
   b. We may disclose your protected health information to other physicians, anesthesia providers and laboratories that may be treating you or consulting with us regarding your care.
   c. We may disclose your protected health information to those who may be involved in your care after you leave here, such as family members or your personal representative.

2. **Payment.** We will use your protected health information to obtain payment for the services we provide to you. We may also disclose your protected health information to another provider involved in your care for their payment activities. Here are some examples of how we may use or disclose your protected health information for payment:
   a. We may communicate with your health insurance company to get approval for the services we render, to verify your health insurance coverage, to verify that particular services are covered under your insurance plan, and to demonstrate medical necessity.
   b. We may disclose your protected health information to anesthesia care providers involved in your care so they can obtain payment for their services.

3. **Health Care Operations.** We may use and disclose your protected health information to facilitate our own health care operations and to provide quality care to all of our patients. Health care operations include such activities as: quality assessment and improvement; employee review activities; conduction or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance reviews; business planning and development; and business management and general administrative activities. In certain situations, we may also disclose your protected health information to another provider or health plan for their health care operations. Here are some examples of how we may use or disclose your protected health information for health care operations:
   a. We may use your protected health information to review our treatment and services and to evaluate the performance of our staff in caring for you.
   b. We may combine protected health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.
   c. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes.
   d. We may also use or disclose your protected health information in the course of maintenance and management of our electronic health information systems.

4. **Other Uses and Disclosures.** As part of the functions above, we may use or disclose your protected health information to provide you with appointment reminders, to inform you of treatment alternatives, or to provide you with information about other health-related benefits and services which may be of interest to you.

Uses and Disclosures of Protected Health Information Permitted without Authorization Required or Opportunity for the Individual to Object

The Federal privacy rules allow us to use or disclose your protected health information without your authorization and without your having the opportunity to object to such use or disclosure in certain circumstances, including:

1. **When Required By Law.** We will disclose your protected health information when we are required to do so by federal, state, or local law.

2. **For Public Health Reasons.** We may disclose your protected health information as permitted or required by law for the following public health reasons:
   a. For the prevention, control, or reporting of disease, injury or disability;
   b. For the reporting of vital events such as birth or death;
   c. For public health surveillance, investigations, or interventions;
   d. For purposes related to the quality, safety, or effectiveness of FDA-regulated products or activities, including:
      - Collection and reporting of adverse events, product defects or problems, or biological product deviations
      - Tracking of FDA-regulated products
      - Product recalls, repairs, or lookback,
      - Post-marketing surveillance
   e. To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease or condition;
   f. Under certain limited circumstances, to report to an employer information about an individual who is a member of the employer's workforce.

3. **To Report Abuse, Neglect, or Domestic Violence.** We may notify government authorities if we believe a patient is a victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically authorized or required by law, or when the patient agrees to the disclosure.

4. **For Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight.

5. **For Judicial or Administrative Proceedings.** We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. We may disclose your protected health information in response to a subpoena, discovery request, or other lawful process that is not accompanied by an order of a court of administrative tribunal if we have received satisfactory assurances that you have been notified of the request or that an effort has been made to secure a protective order.

6. **For Law Enforcement Purposes.** We may disclose your protected health information to a law enforcement official for law enforcement purposes, including:
   a. Wound or physical injury reporting, as required by law.
   b. In compliance with, and as limited by the relevant requirements of a court order or court-ordered warrant, a subpoena, summons, or similar process.
   c. Identification or location of a suspect, fugitive, material witness, or missing person.
   d. Under certain limited circumstances when you are the victim of a crime.
   e. Alerting law enforcement of the death of an individual where there is suspicion that the death may have resulted from criminal conduct.
   f. Reporting criminal conduct that occurred on the premises of the provider.
   g. In an emergency to report a crime.

7. **To Coroners, Medical Examiners, and Funeral Directors.** We may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. In some cases such disclosures may occur prior to, and in reasonable anticipation of, the individual's death.

8. **For Organ or Tissue Donation.** We may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating donation and transplant.

9. **For Research Purposes.** We may use or disclose your protected health information for research purposes when an institutional review board that has reviewed the research proposal and protocols to safeguard the privacy of your protected health information has approved such use or disclosure.

10. **To Avert a Serious Threat to Health or Safety.** We may, consistent with applicable law and standards of ethical conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or that of the public.

11. **For Specialized Government Functions.** We may use or disclose your protected health information, as authorized or required by law, to facilitate specified government functions related to military and veterans activities; national security and intelligence activities; protective services for the President and others; medical suitability determinations; correctional institutions and other law enforcement custodial situations.

12. **For Workers' Compensation.** We may use and disclose your protected health information, as necessary, to comply with workers' compensation laws or similar programs.

Uses and Disclosures of Protected Health Information Permitted without Authorization Required but with an Opportunity for the Individual to Object

We may use your protected health information to maintain a directory of patients in our facility. The information included in the directory will be limited to your name, your location in our facility, and your condition described in general terms.

We may disclose your protected health information to a friend or family member who is involved in your medical care or payment for care. In addition, if applicable, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

You may object to these disclosures. If you do not object to these disclosures, or we determine in the exercise of our professional judgment that it is in your best interest for us to disclose information that is directly relevant to the person's involvement with your care, we may disclose your protected health information.

Uses and Disclosures of Protected Health Information which You Authorize

Other than the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. Authorizations are for specific uses of your protected health information, and once you give us authorization, any disclosures we make will be limited to those consistent with the terms of the authorization. You may revoke your authorization, by submitting a revocation in writing, at any time, except to the extent that we have already taken action in reliance upon your authorization.

Your Rights Regarding Your Protected Health Information

You have the following rights regarding your protected health information:

1. **The Right to Request Restriction of Uses and Disclosures.** You have the right to request that we not use or disclose certain parts of your protected health information for the purposes of treatment, payment, or healthcare operations. You also have the right to request that we do not disclose your protected health information to friends or family members who may be involved in your care, or for notification purposes as described earlier in this notice. Your request must be made in writing and must state the specific restriction requested and the individuals to whom the restriction applies.

   We are not required to agree to a restriction you may request. We will notify you if we do not agree to your restriction request. If we do agree to the restriction request, we will not use or disclose your protected health information in violation of the agreed upon restriction, unless necessary for the provision of emergency treatment.

   We may terminate our agreement to a restriction if you agree to the termination in writing; if you agree to the termination orally and the oral agreement is documented, or if we notify you of termination of the agreement and the termination applies only to protected health information created or received by us after you receive the notice of termination of the restriction. *Request for restrictions must be made in writing to the Privacy Officer.*

2. **The Right to Request Confidential Communications.** You have the right to request that you receive communications of protected health information from us by alternative means or at alternative locations. We must accommodate reasonable request of this nature. We may condition the provision of accommodation by requesting information from you describing how payment will be handled, or by requesting specification of an alternative address or alternative form of contact. *Requests for confidential communications must be made in writing to the Privacy Officer.*

3. **The Right to Inspect and Copy Protected Health Information.** You have the right to inspect and obtain a copy of your protected health information that is maintained in a designated record set for as long as we maintain the protected health information. The designated record set is a collection of records maintained by us, which contains medical and billing information used in the course of your care, and any other information used to make decisions about you.

   By law, you do not have a right to access psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding; and protected health information which is subject to a law which prohibits access to protected health information. Depending on the circumstance of your request, you may have the right to have a decision to deny access reviewed.

   We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger you or another person, or is likely to cause substantial harm to another person referenced within the protected health information. You have a right to request a review of a denial of access.

   Requests for access to your protected health information must be made in writing to the Privacy Officer. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request.

   The Right to Amend Protected Health Information. You have the right to request that we amend your protected health information in a designated record set for as long as we maintain that information. In certain cases we may deny your request. If we deny your request you will be notified in writing, and you will have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement of disagreement and if we do so we will provide a copy of our rebuttal to you. *Requests for amendment of protected health information must be made in writing to the Privacy Officer, and must include a reason to support the requested amendments.*

4. **The Right to Receive an Accounting of Disclosures of Protected Health Information.** You have the right to request an accounting of disclosures of your protected health information made by us. This right applies to disclosures made by us except for disclosures: to carry out treatment, payment, or health care operations as described in this Notice or incidental to such use; to you or your personal representatives; pursuant to your authorization; for our directory, or other notification purposes, or to persons involved in your care; or for certain other disclosures we are permitted to make without your authorization.

   Requests for disclosure of accounting must specify a time period sought for the accounting, with the maximum time period being six years prior to the date of the request. We are not required to provide accounting for disclosures made before April 14,2003. We will provide the first disclosure accounting you request during any 12-month period without charge. Subsequent disclosure accounting request will be subject to a reasonable cost-based fee.

5. **The Right to Obtain a Paper Copy of this Notice.** Upon request, we will provide a paper copy of this notice.

Your Rights Regarding Your Protected Health Information

We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. If we change the Notice, we will provide a copy of the revised notice through in-person contact.

Your Rights Regarding Your Protected Health Information

You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated.

If you wish to complain to us, *please do so in writing*, and direct your complaint to the Privacy Officer. **You will not be penalized for filing a complaint.** The privacy officer can be reached at (317) 925-2283.

Contact Information

For further information about this Notice or if you believe that your privacy rights have been violated, please contact:

The Surgery Center of Indianapolis
Attn: Privacy Officer
2007 North Capitol
Indianapolis, IN 46202

Effective Date: This notice is effective April 14, 2003.