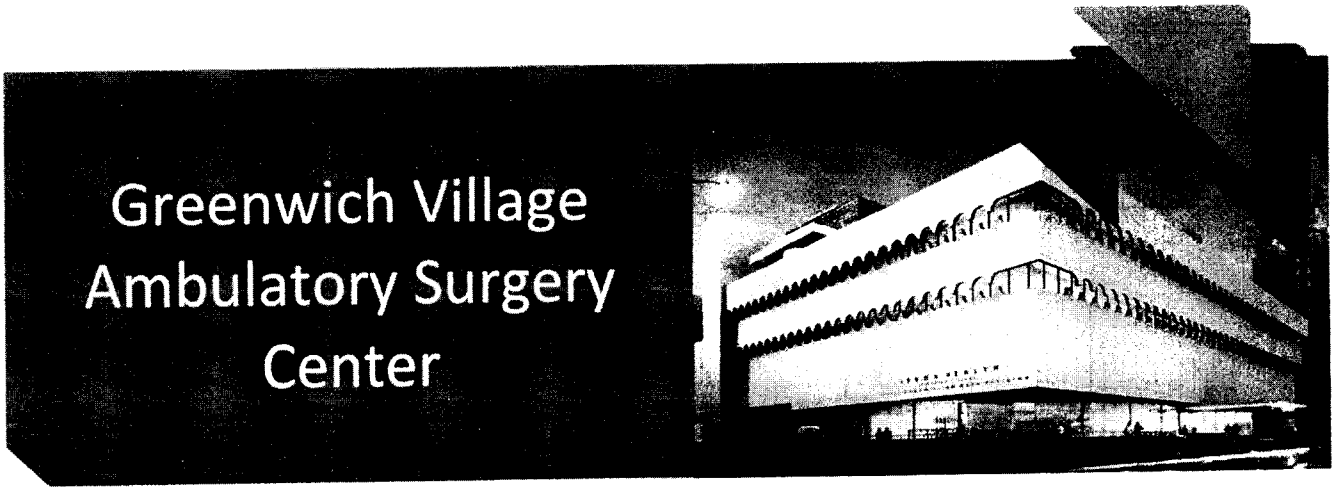

Patient Instruction Packet

Please read the information and complete the documents in this packet prior to the time of your scheduled appointment.

Greenwich Village Ambulatory Surgery Center
200 West 13th St., 4th Floor
New York, NY 10011
Tel: (929) 292-3700
Fax: (646) 396-4094
www.gvasc.net

Northwell Health | Greenwich Village Ambulatory Surgery Center

Please complete all highlighted forms marked with an asterisk and bring entire patient packet with you on the day of your appointment.

Please complete page 8 **ONLY** if your procedure is related with an injury or accident.

Northwell Health | Greenwich Village Ambulatory Surgery Center

200 WEST 13TH ST NEW YORK,NY 10011 | 4TH FLOOR | P: (929) 292-3700 | F: (646) 396-4094

Welcome Notice

Welcome to Greenwich Village Ambulatory Surgery Center(GVASC). Our mission is to provide high-quality medical care and related services to our community, considerate of the specific needs of individual patients. It is the mission of the center to serve all persons in need of medical/surgical care and related services, regardless of age, color, race, creed, national origin, religion, gender, marital status, disability, payor source or any other personal characteristic or qualification, including the ability to pay.

GVASC serves as a valuable health care resource, offering high-quality clinical care across several medical disciplines, including but not limited to Orthopedics, Pain Management and Spine(Neuro).

The center is a licensed by New York State as an Article 28 free standing ambulatory surgery center.

Our community based physicians, surgeons and staff endeavor to achieve excellence in patient satisfaction. GVASC's physicians and staff take pride in serving the healthcare needs of our diverse and widespread community. Our patients and their families have embraced the center as an integral part of their community.

Further information on GVASC can be found on our website: www.gvasc.net

Greenwich Village Ambulatory Surgery Center

PATIENT REGISTRATION

Today's Date _____ Date of Birth _____ Age _____ Social Security# _____

Patient Name _____ Gender **M F** Marital Status **S M W D**
(First Name) (MI) (Last Name)

Address _____
(Street) (Apt#) (City) (State) (Zip Code)(County)

Home Phone _____ Cell Phone _____ Alternate Phone/Email _____

Ethnicity – Do you consider yourself Hispanic/Latino? Y-☐ N -☐ Declined-☐ Unavailable/Unknown-☐ Primary Language _____

Race – Which category best describes your race? American Indian/Alaskan Native-☐ Asian-☐ Black or African American-☐ White-☐

Native Hawaiian/Pacific Islander-☐ Multiracial-☐ Declined-☐ Unavailable/Unknown-☐

Emergency Contact: **Name:** _____ **Telephone:** _____ **Relationship:** _____

Person that will escort you upon discharge from the Center: **Name:** _____ **Telephone #** _____

Employer _____ Occupation _____ Work Phone _____

Address _____
(Street) (City) (State) (Zip Code)

****

Send Report to Dr.: _____ Address _____

Referring Physician Telephone _____ Referring Physician Fax _____

****

Do you have allergies to Latex? ☐ Yes ☐ No

Allergies to food? ☐ Yes ☐No[if yes, please list] _____

Allergies to medications? ☐ Yes ☐No [if yes, please list drug names] _____

****

Primary Insurance Company Name _____ ☐ Hosp ☐ Medical Ins Phone # _____

Address _____ Group # _____ ID # _____

Name of Insured _____ Date of Birth _____ SS # _____ Relationship _____

Secondary Ins. Company Name _____ ☐ Hosp ☐ Medical Ins Phone # _____

Address _____ Group # _____ ID # _____

Name of Insured _____ DOB _____ SSN# _____ Relationship _____

I, the undersigned, have insurance with _____ and assign benefits directly to the provider for all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Patient's signature: _____

Do You Have A Health Care Proxy ☐ No ☐ Yes If Yes, Type: _____ Copy Provided? ☐ N/A ☐ No ☐ Yes

****

By signing below, I acknowledge receiving a copy of the Center's Notice of Privacy Practices and the Patient's Bill of Rights and Responsibilities.

Patient's Signature: _____

If an interpreter is necessary, please sign below indicating the patient understands and agrees to the terms herein.

Interpreter's Signature: _____

Northwell Health | Greenwich Village Ambulatory Surgery Center

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Pre-Procedure Instructions

You will be contacted by one of our nurses the day prior to your scheduled procedure. If you miss our call, please call Greenwich Village Ambulatory Surgery Center at (929)292-3708.

Food & Fluid Restrictions

The night before your procedure do not eat or drink anything after midnight including but not limited to water, gum or candy, unless otherwise specified by an anesthesiologist.

For children individualized requirements are per anesthesiologist instructions to parents

Medications

If you are taking aspirin, aspirin like products and/or Coumadin, Plavix or other blood thinning medications consult your physician on your upcoming surgery for directions regarding these medications.

Arrival

Patients are required to arrive one hour prior to their schedule surgery time unless specified in pre-operative phone call with nurse. Patients may be required to arrive earlier based on type of anesthesia or procedure to facilitate adequate preparation and to maintain the schedule.

Personal Possessions Policy

Surgery Patients will be assigned a private locker for their possessions to be stored during their surgery.

Please **DO NOT** wear jewelry, **DO NOT** bring firearms/personal protection devices, **DO NOT** bring laptops, ipods or any other valuables when you come to the center.

Please note that GVASC assumes no responsibility for lost, stolen or misplaced items.

Escort

As a matter of patient safety, Greenwich Village Ambulatory Surgery Center enforces the New York State Ambulatory Surgical Center **requirement that all patients having a procedure in our facility have an escort,** that is, a companion, family member or friend, to accompany you home following your procedure.

Please Note That Your Procedure Cannot Be Performed Unless Your Escort Is Verified.

Thank You for Your Cooperation

Northwell Health | Greenwich Village Ambulatory Surgery Center

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Patient Transportation / Contact Information

Patient's Name: _____

Person accompanying you home: _____

Relationship to you: _____

Phone/Cell number: _____

Please check the following:

- ☐ They are waiting here
- ☐ We need to call them

If your ride is coming back to pick you up, how much notice do they need?

_____

_____

Patient EMAIL (for follow up purposes; NOT FOR marketing purposes)

_____

It is our duty and pleasure to make sure that you fully understand your discharge instructions. A member of the nursing staff will be calling you on your first post- operative day (or Monday if your procedure takes place on Friday) to see how you are doing as well as to address any questions or concerns you may have. In the event we cannot reach you, we will leave a message at the provided number of your choice

Best Contact Number: _____

_____

(Signature Patient/Parent/Conservator/Guardian)

Greenwich Village Ambulatory Surgery Center

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT

Name:_____ Med. Rec. #: _____

Physician: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct the above named medical facility, having treated me, to release governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I also authorize Greenwich Village Ambulatory Surgery Center, LLC, to release medical information in the event of any emergency transfer to an Acute Care Facility.

If I am transferred to or admitted to other institutions in relation to my procedure, I authorize the release of all my medical records pertaining to that transfer or admission to Greenwich Village Ambulatory Surgery Center.

_____ _____

Signature of Patient or Authorized Representative Date

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to the above named medical facility sufficient monies and/or benefits to which I may be entitled for government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent.

I, the undersigned, have insurance with_____and assign benefits directly to the provider for all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Patient or Authorized Representative Date

CONSENT FOR LABORATORY BILLING

During the course of your procedure, it may be necessary for your physician to obtain and send tissue samples, blood samples or request other laboratory testing. New York State requires clinical laboratories to directly bill patients for their testing services. In other words, they may not present a bill for its services to any person other than the person who is the recipient of the services, or that person's legal representative. Therefore, it is necessary for the Center to receive authorization from the Patient in order for us to allow the laboratory to bill your insurance company for you. If you do not want the laboratory to bill your insurance company, than billing services will go directly to you as the Patient.
Please complete and sign below so that we may direct this issue in the proper manner. Thank you for your cooperation.

[ ] Yes, I am giving the laboratory permission to bill my insurance company

[ ] No, I do not give the laboratory permission to bill my insurance company. I am aware that I am responsible for the payment of services directly to the laboratory.

_____ _____

Signature of Patient or Authorized Representative Date

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER Tile XVIII of The Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician organization to submit a claim to Medicare for payment to me.

_____ _____

Signature of Patient or Authorized Representative Date

*The signature of the patient must be obtained unless the patient is an un-emancipated minor under the age of 18 or is otherwise incompetent to sign.

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Place Patient Label

ASC Accident/Injury Questionnaire

Please fill out this questionnaire **ONLY** if your procedure is related to an injury/accident.

Due to regulatory changes as of October 1st, 2015, GVASC may require additional information regarding your visit. Please complete this questionnaire with as much detail as possible to accurately bill your insurance carrier/ No fault Carrier/Worker's Compensation Board.
Please be advised that we may contact you about the questions on this page if we require. additional information.

Thank you for your cooperation.

When did the injury/accident happen? (for example: April 2015)

Where did the injury/accident happen? (for example: At home, at work, on the street)
***If it happened at work, what do you do for a living? (for example: construction worker)**

How did the injury/accident happen? (for example: I slipped on the wet floor)

What body part was injured? (for example: right knee)

X_____ _____

Signature of Patient or Patient Representative Date

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Financial Policy

Greenwich Village Ambulatory Surgery Center, GVASC, is a for-profit out-patient surgical facility dedicated to providing physicians and patients a safe and effective environment for the performance of various non-emergent procedures. The facility will bill an appropriate "facility fee" for the performance of procedures: Physicians who use the facility, including anesthesiologists will bill a separate "professional fee" to be paid directly to themselves. This fee has no relationship to the facility payment other than they are generated at the same procedure. Billing, payment, collection and participation with carriers may differ considerably between the facility and physician involved in the procedures at the facility.

A professional attitude shall be used whenever communicating with patients and insurance companies regarding payment for services rendered. Appropriate staff will assure that the patient understands the implications of his insurance coverage, if any and the resulting personal financial obligation and responsibility for payment for services rendered.

As you know, the world of health insurance has become increasingly confusing and complex for patients and physicians alike. For this reason, we would like to bring to your attention that we are legally required to bill you for any applicable co-payments or co-insurance and/or deductibles which your insurance plan requires you to personally pay under the terms of your insurance policy according to the State of New York Insurance Department.

*Please see NYS Insurance Department Opinion 03-04-09, *Non-Participating Healthcare Provider; Balance Billing* http://www.dfs.ny.gov/insurance/ogco2003/rg030409.htm

The Federal and State governmental agencies that oversee the health insurance industry have consistently taken the position that the routine waiver of co-payments and co-insurance by healthcare providers may constitute insurance fraud by the insured and the physician. Within 6 months of receiving a response from your carrier, you will receive a "balance bill". These amounts reflect that portion of our facility fees which were not paid by your insurance company and that remain as your personal responsibility. According to the State of New York Insurance Department opinion referenced above, a decision in the exercise of business judgment by a physician not to pursue the full legal remedies available to collect a debt would not constitute insurance fraud. If payment of your full outstanding balance is not financially feasible for you at this time, please call our office and we will try to work out a mutually-agreeable payment plan that you can afford to pay over a reasonable period of time.

For patients who have a sizable financial obligation after payment by insurance, or for patients who have no insurance coverage, a payment contract or the use of a credit card may offer the opportunity to satisfy the financial obligation. For those patients wishing to satisfy their balance due via a financial agreement, the patient or responsible party will be required to sign a contract prior to the procedure. Patient or responsible party will be given a copy of the signed agreement, and the original will be maintained by the Accounts Receivable Office.

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Patient Financial Responsibilities

Co-Payment and Deductible

You are responsible for your deductible and co-payment. Your co-payment is due at the time of service. If your deductible has not been satisfied, payment may also be required at the time of service.

Non-Covered Services

If services provided are not are not covered by your health insurance carrier, you may be responsible for payment for those services. Your signature below constitutes agreement to pay for such services.

Out-of-Network Services

As an out-of-network outpatient surgery facility, we do not have a contract with your health insurance carrier. As a result, you may be financially responsible for a higher share of the fees than a facility within your PPO network. Your signature, below, constitutes agreement to pay for portion of the out-of-network fees.

Please refer to the FAQ for additional information about your out-of-network insurance options.

Member Appeal Authorization

I hereby authorize Greenwich Village Ambulatory Surgery Center and its agents to represent me, and act on my behalf regarding my medical health claim determination in the event my claim is denied and/or if my claim is processed below my lower level of benefits.

I authorize my insurance carrier to release my protected health information to my representative for the purpose of resolving the appeal and I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law.

This authorization will expire upon resolution of this appeal.

Patient Signature or Legal Guardian *Print Name* *Date*

Employee Signature *Date*

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PATIENT SELF-DETERMINATION ACT/ADVANCE DIRECTIVES

Greenwich Village Ambulatory Surgery Center supports each patient's right to develop an advance directive; the Center will not condition the provision of care or discriminate against an individual based on whether or not an advance directive has been executed; and will provide education for its staff, patients and the community, as applicable, related to the patient self-determination act/advance directives.

NOTICE OF LIMITATION- ***Greenwich Village Ambulatory Surgery Center will always attempt to resuscitate a patient and transfer that patient to a hospital in the event of deterioration.***

If you are interested you may request resource information regarding self-determination. The information includes:

- The description of state law prepared by the Department of Health entitled, "Planning In Advance For Your Medical Treatment".
- The pamphlet prepared by the department of health entitled, "Appointing Your Health Care Agent -- New York State's Proxy Law".
- A model "New York Living Will".
- The fact sheet entitled, "Deciding About CPR Do Not Resuscitate Orders (DNR)".
- A handout entitled, "Ten Basic Questions And Answers For Consumers On The Patient Self-Determination Act".
- A handout entitled, "Definitions For A Health Care Proxy".

Our staff will inquire and document your present status concerning advance directives during the pre-procedure assessment in the medical record.

If you have executed an advance directive and have brought a copy, this copy will be filed in your medical record.

If copies are not immediately available, the types of advance directives and the name and address of the healthcare agent are obtained and documented in your medical record.

If you request additional information or wish to make an advance directive, the Center will supply you with appropriate information and direction.

The Center will comply with the health care decisions made in good faith by a health care agent to the same extent as decisions made by a competent adult.

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POLICY ON ADVANCED DIRECTIVES, LIVING WILLS, AND DO NOT RESUSCITATE (DNR) ORDERS

Do you have *Advanced Directives? YES ☐ NO ☐

Due to the ambulatory nature of your procedure, and in accordance with the policy of this facility:

GVASC will always attempt to resuscitate and/or transfer a patient to the hospital in the event of deterioration.

If you wish for your Advanced Directive, Living Will, or DNR to remain in effect during your procedure, you will have the option of having the procedure done in another facility that accepts this status. By signing this form, you are agreeing to the postponement of your directives until you leave the facility.

_____ _____

Patient's Signature or Legal Guardian **Date**

_____

Print Patient's Name

_____ _____

Witness (Sign and Print) **Date**

Health Care Proxy

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

_____

_____

*as my health care agent to make any and all health care de*cisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby

appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*: _____

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: _____

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____ Date _____

Name of Witness 1
(print) _____

Name of Witness 2
(print) _____

Signature _____ Signature _____

Address _____ Address _____

_____ _____

NEW YORK STATE | Department of Health

Northwell Health | Greenwich Village Ambulatory Surgery Center

200 WEST 13TH ST NEW YORK,NY 10011 | 4TH FLOOR | P: (929) 292-3700 | F: (646) 396-4094

Patient's Rights and Responsibilities

Patient Bill of Rights:

As a patient in our ambulatory facility and consistent with the law, you have the right to:

1. Understand and use these rights. If for any reason you do not understand or need help, the center must provide assistance, including an interpreter
2. Receive services without discrimination in regard to age, race, color, sexual orientation, gender identity, gender expression, religion, source of payment, or disability.
3. Receive quality care and treatment given with respect, consideration and dignity in a clean and safe environment free of unnecessary restraints
4. Receive care free of all forms of harassment
5. Appropriate privacy for you and your health information.
6. Access to your medical record.
7. Participate in all decisions concerning your care to include, diagnosis, treatment and prognosis
8. Refuse treatment and be told what effect this may have on your health.
9. Know the names, positions, functions and credentials of all staff involved in your care
10. Receive all the information you need to give informed consent including risks, benefits and alternatives
11. Change providers if other qualified providers are available
12. Refuse to participate in experimental research
13. Receive information on this facility's policies on advance directives and privacy practices
14. Be informed if your physician does not carry malpractice insurance
15. Be informed of your responsibilities, conduct, and facility's rules affecting your treatment
16. Knowledge of services provided at this facility
17. Discharge instructions and information about after hours care
18. Be informed about charges for services and to receive a itemized copy of your bill upon request
19. Express complaints about your care and services provided by the facility and to have the facility investigate such complaints. The facility is responsible for providing you or your designee with a written response within 30 days of the findings of the investigation.
20. Voice a grievance to the NYS Department of Health without fear of reprisal.

Patient Responsibilities:

As a patient in this facility, you are responsible for:

1. Providing accurate and complete information related to your health, reporting perceived risks about your care and reporting any unexpected changes in your health.
2. Asking questions when you do not understand what a staff member has told you about your care.
3. Providing a responsible adult to transport you from the facility and remain with you for 24 hours if required by your provider.
4. Following the treatment plan established by your physicians, including the instructions given to you by healthcare professionals carrying out the physician's orders.
5. Being respectful and considerate of other patients and the facility's personnel.
6. Providing your health insurance information and assuring financial obligation is fulfilled.
7. Understanding the responsibility and consequences of not following the practitioner's instructions.

Office of the Medicare Beneficiary Ombudsman

Visit ***www.medicare.gov*** *or call* ***1.800.MEDICARE (1.800.633.4227)*** *or use www.cms.hhs.gov/****center/ombudsman***

New York State Department of Health's Metropolitan Area Regional Office (MARO): **800 804-5447.**

Office for Civil Rights: **https://www.hhs.gov/ocr/**

Grievances or safety concerns about our outpatient facility should be referred to our Medical Director or Administrator at **929-292-3708**

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OWNERSHIP DISCLOSURE

Due to concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, New York State passed a law, prohibiting the physician, with certain exceptions, from referring you for clinical laboratory pharmacy or imaging services to a facility in which the physician or his/her immediate family members have a financial interest. If any of the exceptions in the law apply, or if he/she is referring you for other than clinical laboratory, pharmacy, or imaging services, he/she can make the referral under one condition. The condition is that he/she disclose this financial interest and tell you about alternative places to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care.

For more information about alternative providers, please ask your physician, or his/her staff. They will provide you with names and addresses of places best suited to your individual needs that are nearest to your home or place of work.

Statutory authority; *Public health law, §238 a (10)*

The Following Persons/Physicians Are the Owners of The Center:

Northwell Health

Northwell Health | Greenwich Village Ambulatory Surgery Center

200 WEST 13TH ST NEW YORK,NY 10011 | 4TH FLOOR | P: (929) 292-3700 | F: (646) 396-4094

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address worker' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health car item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide on accounting a year for free but will charge a reasonable, cost-based fee if you ask for another on within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any actions.

File a complaint if your feel your rights are violated

- You can complain if your feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints/
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we shar your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, to others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead to share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Northwell Health | Greenwich Village Ambulatory Surgery Center

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Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat You

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Examples: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet any conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hippa/understanding/consurmers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies

Address workers' comprehension, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breech occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described in this notice and give you a copy of it.
- We will not use or share our information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind

For more information see: www.hhs.gov/ocr/privacy/hippa/understanding/consumer/noticepp/html

Changes to the Terms of Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Other instructions for Notice

- Effect date: April 1st, 2017
- Privacy Official: Teodoro Cafe, email tcafe@gvasc.net, (929) 292-3700

Northwell Health | Greenwich Village Ambulatory Surgery Center

200 WEST 13TH ST NEW YORK,NY 10011 | 4TH FLOOR | P: (929) 292-3700 | F: (646) 396-4094

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement. We weren't able to communicate with the patient.

Other *(Please provide specific details)*

_____

_____

_____

_____

_____ _____

Employee signature **Date**

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Patient Acknowledgment of Advance Notices

I hereby acknowledge receipt of the Center's **HIPAA Notices of Privacy Practices** and acknowledge that the Center may use and disclose my health information for the purposes of treating me, obtaining payment for services rendered to me and performing routine healthcare operations and services in the Center.

By signing below, I hereby acknowledge that I received written the notice of the **Patient's Bill of Rights and Responsibilities** prior to the start of my procedure;

I hereby acknowledge that I received a written **Ownership Disclosure** listing the physicians and or parties who have financial interest or ownership in the ASC facility;

I hereby acknowledge that I was offered written information concerning **Advance Directives**;

I understand that I am **required** to bring an **Escort** to take me home on the day of the procedure;

I have received a copy of the **Financial Policy** and I understand that I may be financially responsible for any outpatient facility charges, as outlined in my insurance coverage for copayments, coinsurance and deductibles.

_____

First name M.I. **Last Name**

_____

Signature Date

_____

Witness Date

_____

Interpreter Date

Northwell Health | Greenwich Village Ambulatory Surgery Center

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Dear Patient:

As of March 28 2007, the state of New York, Office of Statewide Planning and Research Cooperative (SPARCS) mandates that ambulatory surgery centers collect individual encounter data (New York Health and Safety Code, Division Section 400.18 of Title 10, (Health) of the Official Compilation of Codes, Rules, and Regulations of the State of New York (NYCRR)) is amended to read as follows: All facilities licensed under article 28 of the Public Health Law that provide ambulatory surgery services shall submit in an electronic format for each patient surgical visit. In April 1983 and June 1985, the State Hospital Review and Planning Council adopted additional regulations regarding the reporting of ambulatory surgery data to the New York State Department of Health. Additional specifications for ambulatory surgery appear in Section 755.1 and Section 755.10.

The data will be used for health planning projects, including management of state health care delivery and public health programs, efficient administration of healthcare services, continuous improvement in the quality of care provided by hospitals and ambulatory surgery centers, effective procurement of healthcare services, and identification and correction of disparities in healthcare access and outcomes. Individually identifiable patient information is protected and encrypted within the State system. This data is private and will be recorded for demographics only, without release of patient name or personal information of this nature.
In addition to information collected at the time when surgery is scheduled, we also need you to select your race, ethnicity, and principal language spoken:

RACE:	
❑ R1 American Indian or Alaska Native	❑ R3 Black or African American
❑ R2.01 Asian Indian	❑ R4.01.001 Native Hawaiian
❑ R2.06 Chinese	❑ R4.02.001 Guamanian or Chamorro
❑ R2.08 Filipino	❑ R4.01.002 Samoan
❑ R2.11 Japanese	❑ R4. Other Pacific Islander
❑ R2.12 Korean	❑ R5 White
❑ R2.19 Vietnamese	❑ R9 Other Race
❑ R2. Other Asian	
PRINCIPAL LANGUAGE SPOKEN:	**ETHNICITY:**
❑ ENG - English	❑ E1.02 Mexican, Mexican American, Chicano/a
❑ CHI – Chinese	❑ E1.06 Puerto Rican
❑ GER – German	❑ E1.07 Cuban
❑ SPA – Spanish	❑ E1. Another Hispanic, Latino/a, or Spanish
❑ FRE – French	❑ E2 Not of Hispanic, Latino/a, or Spanish Origin
❑ Other – _____	❑ E9 Unknown

If you have any questions, please contact the Statewide Planning and Research Cooperative System (SPARCS) at 1-866-881-2809. Additional information is available on the internet at:
http://www.health.ny.gov/statistics/sparcs/

Thank you very much.