Patient Scheduling Policy

In order to schedule a patient for a procedure at the center the following paperwork is needed:

From the surgeon's office	*From the patient*
-Patient Registration Form	-Medical Reconciliation
-Bergen-Passaic Consent Form	-Pre-Operative Health Questionnaire
-History and Physical (H&P)	-CFC Information Packet Acknowledgement Form
-Pre/Post Op Orders Form	-Hardship Application (if applicable)
-Ocular History	
-IOL Diopter Form (if applicable)	

For your convenience all of the scheduling and patient information forms are available on the center's website at "*BPSurgery.com*"

The registration form should be faxed at least **one week** prior to the date of surgery so that the surgical schedule may be arranged. This will allow the center to provide the best service to you and your patients.

The center's Scheduling Coordinator will call your office regarding any missing information as soon as possible before surgery and will send the surgery schedule to your office with confirmation of transportation and/or fees.

Included with the scheduling paperwork is a letter from Bergen-Passaic to the patient's medical doctor, regarding the History and Physical (H&P) form to be completed. Please instruct the patient to give both the letter and H&P form to his/her medical doctor.

Medical clearance examinations must take place within 30 days of the procedure.
Please verify that all exams have been completed and that the results will be forwarded to the surgery center no later than 5 business days prior to the date of surgery.

Please note if the necessary paperwork is not received your case(s) may be cancelled.

The following patient information is also available on our website

- Advance Directive Policy
- Privacy Practices Statement
- Translation Services Statement
- Patient Rights Statement
- Center Directions
  Patient Information

BERGEN-PASSAIC EYE SURGERY CENTER

Phone: (201) 414-5649
Fax: (201) 398-913

Prior to your surgery date

- **Medical clearance:** Medical clearance, including a complete "history and physical" is required prior to surgery. Please make arrangements to see your medical doctor in advance of your scheduled surgery date. The medical clearance paperwork to be completed by your medical doctor will be given to you by your surgeon's office. The paperwork should be faxed to the center at least 1 week prior to your surgery date. Fax # 201-398-9132

  Please note: The history and physical expires after 30 days.

- **Medication:** Please take all medications as prescribed by your physician, including anticoagulants (blood thinners and aspirins), unless instructed otherwise by your medical doctor.

The day of surgery

- **Medication:** Please continue taking take all medications as directed by your medical doctor except insulin or oral diabetes medications.

  Please bring a list of the medications you take, including the name, strength and time(s) you take the medication to the surgery center.

- **Nourishment:** Please refrain from eating or drinking 8 hours prior to surgery (you may have a sip of water to help you swallow any pill medication(s) that you take.)

  If you have diabetes, please take your blood sugar and carry a snack or juice in case your blood sugar becomes low.

- **Clothing:** Please wear loose fitting clothing, a button front shirt and comfortable shoes. Please do not wear pantyhose, makeup, or nail polish.

- **Please bring the following items with you to the center:**
  - Insurance card(s)
  - Identification
  - Advanced Directive or Living Will
  - Durable Medical Power of Attorney

  Please leave your valuables home. A locker will be provided to secure your necessary items.

- **Upon arrival at the surgery center:**
  - The receptionist will welcome you for check-in and assist with the necessary paperwork
  - Eye drops will be administered at different intervals
- **Expect to be at the center for at least one to four hours.**

BERGEN-PASSAIC EYE SURGERY CENTER

PATIENT REGISTRATION

The surgery center requires the following information in order to file an insurance claim(s) on the patient's behalf. Claims are processed by the insurance company according to the patient's specific plan benefits; Deductibles, Co-insurance, and Non-covered service charges may apply and are the responsibility of the patient.

PATIENT NAME		DATE OF BIRTH	SEX	RACE
ADDRESS				
HOME PHONE	CELL PHONE	WORK /ALTERNATE PHONE	SOCIAL SECURITY NUMBER	

FLU VACCINE □ Y □ N	PNEUMO VACCINE □ Y □ N	DEFIBRILLATOR □ Y □ N	ADVANCED DIRECTIVE □ Y □ N
ALLERGIES □ Y □ N Please List	LATEX ALLERGY □ Y □ N Reaction	TB STATUS □ Pos (+) □ Neg (-)	
EXPOSURE TO COMMUNICABLE/INFECTIOUS DISEASE □ Y □ N Please Explain	ANY SPECIAL NEEDS □ Y □ N Please List		

PRIMARY CARE PHYSICIAN	PHONE	FAX
EMERGENCY CONTACT	PHONE	RELATIONSHIP TO PATIENT

SURGEON	DATE OF SURGERY	TRANS	FEE
PROCEDURE (Description & Code)	DIAGNOSIS (Description & Code)		EYE
PROCEDURE (Description & Code)	DIAGNOSIS (Description & Code)		EYE

PRIMARY INSURANCE COMPANY	IDENTIFICATION #	GROUP #
INSURANCE COMPANY ADDRESS	PHONE	REFERRAL/AUTHORIZATION
POLICYHOLDER	DATE OF BIRTH	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE COMPANY	IDENTIFICATION #	GROUP #
INSURANCE COMPANY ADDRESS	PHONE	REFERRAL/AUTHORIZATION
POLICYHOLDER	DATE OF BIRTH	RELATIONSHIP TO PATIENT

I, _____, authorize payment of Medicare and/or other insurance benefits be made on my behalf to the Bergen-Passaic Eye Surgery Center ("Bergen-Passaic") for any services furnished to me by this provider. I accept responsibility for payment for any service(s) not covered by my insurance.

I authorize Bergen-Passaic to use/and or disclose my health information to CMS and its agents or any other provider or insurance carrier for the purpose of determining the benefits payable for related services, processing claims and/or care or treatment. I understand that I may revoke this consent at any time by notifying Bergen-Passaic in writing and that this authorization will be effective until such time as I revoke it.

I authorize Bergen-Passaic to contact me, my emergency contact, and/or leave information on my answering machine as necessary.

_____ _____

Date Signature of Patient or Legal Guardian

Patient Name: _____

NOTICE OF EXCLUSIONS FROM HEALTH PLAN BENEFITS

There are items and services for which your health plan will not pay.

Your health plan **does not** pay for all your health care costs. The health plan only pays for covered benefits. Some items are not covered benefits and your insurance will not pay for them.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing you will have to pay for them yourself at the time of surgery.

Before you make a decision, you should read this entire notice carefully.

- If you do not understand why your insurance will not pay, ask us to explain.
- Ask us how much these items or services will cost you.

Your health plan will not pay for:

□ The accommodating, presbyopia, astigmatism, or multifocal correcting aspect of the IOL _____ $ _____
List Premium intraocular lens (IOL)

□ Femtosecond Laser use in cataract surgery $ _____

□ ORA, intraoperative wavefront aberrometer, use during cataract surgery $ _____

Total: $ _____

Because it does not meet the definition of any covered benefit. Your policy does may not cover cosmetic refractive surgery using any technology or procedure including the ORA, the Femtosecond Laser, and/or accommodating, presbyopia, astigmatism or multifocal correcting premium IOLs.

Your health plan will only pay for standard cataract surgery including the required examinations, testing, follow-up care, and a conventional IOL.

Refractive service(s) with the ORA, Femtosecond Laser, and/or implantation of a Premium IOL are not medically necessary. Choosing a refractive service(s) and/or Premium IOL is optional.

In addition to the cost of the non-covered items and services, you are responsible for the usual copayments and deductibles associated with covered services (i.e. cataract surgery).

I have read and understood this agreement and accept full financial responsibility for the non-covered services described above.

Signature:	**Date:**

BERGEN-PASSAIC EYE SURGERY CENTER
18-01 Pollitt Dr, Suite 4 Fair Lawn, New Jersey 07410 Phone: (201)414-5649

Patient Name: _____ **ID#** _____

Advance Beneficiary Notice Of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the Premium IOL and/or refractive procedure(s) below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the Premium IOL and/or refractive service(s) below.

Item(s)	Reason(s) Medicare May Not Pay:	Estimated Cost:
☐ Premium IOL _____ Print lens name	Medicare has established specific policies concerning presbyopia and astigmatism correction that declare these added items and services to be not covered and the financial responsibility of the beneficiary. CMS Ruling No 05-01 (May 3, 2005), Transmittal 636 (August 5, 2005); CMS Ruling No 1536-R (January 22, 2007)	$_____
☐ Femtosecond laser use in surgery	The Medicare law, Social Security Act §1862(a)(1)(A), does not cover any service that is not required by medical necessity "…for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."	$_____
☐ ORA (intraoperative wavefront aberrometer) use during cataract surgery	National Coverage Determination §80.7 specifies that "…keratoplasty for the purpose of refractive error compensation is considered a substitute or alternative to eyeglasses or contact lenses, which are specifically excluded … keratoplasty to treat refractive defects are not covered."	$_____
	Total:	$_____

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- **Ask us any questions that you may have after you finish reading.**
- **Choose an option below about whether to receive the Premium IOL and/or the refractive services listed above**

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the Premium IOL and/or refractive service(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays and/or deductibles.

☐ **OPTION 2.** I want the Premium IOL and/or refractive service(s) listed above, but do not bill Medicare. You may ask to be paid now, as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the Premium IOL and/or refractive service(s) listed above. I understand that with this choice, I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay**.

Additional Information: Refractive service(s) with the ORA, Femtosecond Laser, and/or implantation of a Premium IOL are not medically necessary. Choosing a refractive service(s) and/or Premium IOL is optional.

In addition to the cost of the non-covered items and services, you are responsible for the usual copayments and deductibles associated with covered services (i.e. cataract surgery).

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

BERGEN-PASSAIC
CATARACT SURGERY & LASER CENTER, INC

Laser Consent Form

Name of Patient _____

Name of Surgeon _____

Your surgeon has recommended the following laser procedure on your ☐ Right Eye ☐ Left Eye

☐ Yag Laser Capsulotomy ☐ Argon Laser Trabeculoplasty ☐ Selective Laser Trabeculoplasty

☐ Peripheral Laser Iridotomy ☐ Other _____

This consent is given by you to Bergen-Passaic Cataract Surgery & Laser Center, Inc. (the "Facility").

This procedure involves risks of unsuccessful results, complications, or injury from both known and unforeseen causes. You have the right to be informed of such risks as well as the nature of the procedure, the expected benefits or effects, and the available alternative methods of treatment, including but not limited to non-treatment and their risks and benefits. You have the right to be informed of the likelihood of success, any problem(s) associated with recuperation and the possible result of non-treatment.

You have the right to be informed whether your surgeon has any independent medical research or economic interests related to the performance of the proposed procedure; if the Facility or its staff have any business relationship between individuals treating you or with any educational institutions involved in your care; of any professional relationship to another healthcare provider or institution that may suggest a conflict of interest. Some surgeons have varying degrees of financial interest in the Facility, and, in such case, you have been offered an alternate site for the procedure.

Dr_____ ☐ does have ☐ does not have a financial interest in the Facility.

By signing below, I certify and acknowledge that: (1) I have read and understood the information provided in this consent; (2) the procedure(s) set forth above has been adequately explained to me by my surgeon; (3) I have had a chance to ask questions; (4) I have received all of the information I desire concerning the surgical procedure; (5) I have evaluated the nature of the procedure(s), any risks, and the availability of alternatives and (6) I authorize and consent to the performance of the procedure(s), and the provision of supporting medical services as deemed necessary by my surgeon, including but not limited to the administration of topical anesthetic and pre and post-operative therapy. Finally, I certify that at this time I have not withheld any information from my surgeon or the Facility and that I am not pregnant.

_____	_____	_____ ☐ AM ☐ PM	
Signature of Patient or Guardian	Date	Time	
_____	_____		
Printed name of Patient or Guardian	If signed by other than patient, indicate relationship		
_____	_____	_____ ☐ AM ☐ PM	
Signature of Witness	Date	Time	

Surgeon Certification

I certify that the benefits, risks, drawbacks, complications, side effects, and alternative choices of and to the procedure(s) have been fully explained to the patient and/or the patient's legal guardian. I further certify that I have provided sufficient information to the patient and/or the patient's legal guardian to permit the patient or the legal guardian to give informed consent to the procedure(s) listed above. I further certify that I have fully advised the patient of any financial interest that I may have in the Facility and that I have also informed the patient of alternative locations at which the procedure(s) may be performed.

_____	_____	_____ ☐ AM ☐ PM
Signature of Surgeon	Date	Time

CONSENT FOR SURGERY

Name of Patient _____

Name of Surgeon(s) _____

Your surgeon(s) has recommended the following outpatient surgical procedure(s) □ Right □ Left

_____

_____

□ Femto Second Laser □ ORA System □ _____

This consent is given by you to Bergen-Passaic Eye Surgery Center (the "Facility").

This outpatient surgical procedure involves risks of unsuccessful results, complications, injury or even death, from both known and unforeseen causes and no warranty or guarantee is made as to result or cure. You have the right to be informed of such risks as well as the nature of the surgical procedure, the expected benefits, or effects of such surgical procedure, and the available alternative methods of treatment, including but not limited to non-treatment and their risks and benefits. You have the right to be informed of the likelihood of success, any problem(s) associated with recuperation and the possible result of non-treatment. By signing below, you certify and acknowledge that your surgeon has fully explained the surgical procedure(s) with you and that you have evaluated the nature of the procedure(s), any risks, and the availability of alternatives. You further certify that you have asked the surgeon any questions you may have concerning the surgical procedure(s).

You have the right to be informed whether your surgeon has any independent medical research or economic interests related to the performance of the proposed surgical procedure; if the Facility or its staff have any business relationship between individuals treating you or with any educational institutions involved in your care; of any professional relationship to another healthcare provider or institution that may suggest a conflict of interest. Some surgeons have varying degrees of financial interest in the Facility and, in such case; you have been offered an alternate site for the procedure.

Dr _____ □ does have □ does not have a financial interest in the Facility.

Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent to or to refuse any proposed operation or procedure at any time prior to its performance. Upon your authorization and consent indicated by your signature below, the above named surgical procedure, together with any different or further procedures that in the opinion of the surgeon may be indicated due to any emergency, will be performed on you as well as the administration of the necessary pre-operative and post-operative medications.

By your signature below, you authorize the disposal of any tissues, members, organs or other matter of any description that are removed surgically.

The surgical procedure(s) will be performed by the surgeon named above (or in the event that the surgeon is unable to perform or complete the procedure, a qualified substitute surgeon chosen by your surgeon), together with associates and assistants, including anesthesiologists, from the medical staff of the Facility to whom the supervising physician or surgeon may assign designated responsibilities.

The person(s) in attendance for the purpose of performing the surgical procedure(s), administration of anesthesia and other medical services are not agents, servants, or employees of the Facility.

By signing below, you agree that: (1) you have read and understood the information provided in this consent; (2) that the surgical procedure(s) set forth above has been adequately explained to you by your surgeon; (3) that you have had a chance to ask questions; (4) that you have received all of the information you desire concerning the surgical procedure; and (5) that you authorize and consent to the performance of the surgical procedure(s), and the provision of supporting medical services as deemed necessary by your surgeon, including but not limited to the administration of anesthetic, pre and post operative therapy, radiology services, and pathology services.

By signing below, you further understand and agree that unless given written instruction to the contrary: (1) following your outpatient surgical procedure you will not drive yourself home or use public transportation; and (2) because your mental alertness may be impaired for several hours following the administration of medication or anesthesia, you agree not to make any decisions or participate in any activities that depend on full mental alertness during that time in accordance with your surgeon's directions; and (3) that admission to a hospital might be necessary and that you agree if your surgeon and/or anesthesiologist decides it is necessary to be admitted to _____ Hospital.

Any OR procedure may be recorded for internal educational, treatment, operational and/or review purposes. A separate consent is not required for these purposes. This institution will maintain the goal of protection of patient privacy in the highest regard. All recordings are kept strictly confidential in a locked media area. Access to this area is restricted to the head scrub tech per shift, under direct supervision of the Director of Nursing. Recordings may be taken for the external educational, research, or scientific goals of the surgeon and/or institution will be utilized only with the express permission and consent of the patient or his or her legally authorized representative by facility's staff, physicians, healthcare professionals and authorized members of the public for the purposed listed above. A distinct and separate consent for recording for these reasons must be documented as obtained from the patient or his/her authorized legal representative. Recordings not used for the purposes listed above will remain in the physical possession of the center and will not be released to any other party for any other purpose unless required by law. Recordings are erased within 2 weeks of the date of recording.

I consent to and authorize the surgical procedure(s) and other services as set forth above. I have fully discussed the surgical procedure(s) with my surgeon and I have evaluated the nature of the procedure(s), any risks, and the availability of alternative options. I have not withheld any information from my surgeon or the Facility. Finally, I certify that at this time, I am not pregnant.

Signature of Patient/Guardian	Date
Printed Name of Patient/Guardian	If signed by other than patient, indicate relationship
Witness to Signature	Date

Surgeon Certification

I certify that the benefits, risks, drawbacks, complications, side effects, and alternative choices of and to the procedure(s) have been fully explained to the patient and/or the patient's legal guardian. I further certify that I have provided sufficient information to the patient and/or the patient's legal guardian to permit the patient or the legal guardian to give informed consent to the surgical procedure(s) listed above. I further certify that I have fully advised the patient of any financial interest that I may have in the Facility and that I have also informed the patient of alternative locations at which the surgical procedure(s) may be performed.

Signature of Surgeon	Date

CfC Information Packet Acknowledgement Form

Patient Name _____

The patient, or person signing for the patient named above, acknowledges receipt of the following information in advance of the date of surgery unless referral to the ASC for surgery is made on that same date; and the referring physician indicates, in writing, that it is medically necessary for the patient to have the surgery on the same day, and that surgery in an ASC setting is suitable for that patient.

- □ Advance Directive Policy
- □ Patient Rights Statement
- □ Notice of Privacy Practices

Authorization to Disclose PHI
Bergen-Passaic Cataract Surgery and Laser Center, Inc is authorized to disclose PHI relevant to my care and/or payment for my care to the person(s) named below.

Print Name of Person to whom the center may disclose PHI	Relationship
Print Name of Person to whom the center may disclose PHI	Relationship

Signature of Patient/Guardian **Date**

Printed Name of Patient/Guardian If other than patient indicate relationship

BERGEN-PASSAIC EYE SURGERY CENTER

PRE-OP HEALTH QUESTIONNAIRE

Patient Name: _____ DOB _____

Height _____ Weight _____

Please indicate if you have, have ever had, or do any of the following	Comments	(Clinical Use Only)
☐ Hypertension ☐ High Cholesterol ☐ Cardiac Dr _____ ☐ Chest Pain ☐ Shortness of Breath ☐ Peripheral Vascular Disease ☐ Heart Attack ☐ Cardiomegaly ☐ Cardiomyopathy ☐ Heart Bypass ☐ Cardiac Stent(s) ☐ Defibrillator or Pacemaker ☐ Abnormal EKG ☐ Abnormal Heart Rhythm / Irregular Beat ☐ Abnormal Stress Test ☐ Abnormal Echocardiogram or Catheterization ☐ Stroke ☐ Seizure ☐ Convulsions		
☐ Asthma or Breathing Problems ☐ Lung Dr _____ ☐ COPD ☐ Bronchitis ☐ Pneumonia ☐ Obstructive Sleep Apnea ☐ Abnormal Chest X-ray ☐ CPAP ☐ Home Oxygen ☐ Severe Coughing, Night Sweats or Fatigue ☐ History of Tuberculosis ☐ Travel outside of the USA ☐ Not Able to Lie Flat		
☐ Blood Thinners ☐ Bleeding Problems / Tendency ☐ Anemia ☐ Jaundice ☐ Hepatitis ☐ Liver Problems ☐ HIV/AIDS ☐ Autoimmune disease ☐ Thyroid ☐ Anxiety Problems ☐ Chronic Back Problems ☐ Glaucoma ☐ Kidney Disease and/or Dialysis Shunt location _____ ☐ Recently been hospitalized ☐ Cancer Type _____ ☐ Breast Surgery ☐ R ☐ L Type: _____ ☐ Other Surgery(s) List _____ ☐ Problems with anesthesia ☐ Personal History ☐ Family History		
☐ Diabetes What was your blood sugar today _____		
☐ Allergies or Reactions to Drugs, Latex, or Foods Please list below _____ _____		
☐ Smoke How much _____/day ☐ Drink Alcohol _____/day ☐ Hearing Aid ☐ Dentures ☐ Caps ☐ Bridges ☐ Loose Teeth		
☐ Take Prescription, Over the Counter or Herbal Medications Please list all medications and dosages below – continue on reverse if necessary Medication Dosage Taken Today _____ _____ ☐ _____ _____ ☐ _____ _____ ☐ _____ _____ ☐ ☐		

_____ _____

Patient Signature **Date**

BERGEN-PASSAIC
CATARACT SURGERY & LASER CENTER, INC

PATIENT MEDICATION RECONCILIATION FORM

Name:	Date of Birth:	Age:

☐ Allergies ☐ No known allergies

Medication Allergy	Reaction	Medication Allergy	Reaction

Current Prescriptive Medications (Please attach an additional form if needed)

Name of Medication (please print)	Dose	How often do you take it?	Continue After Discharge	Stop After Discharge

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs

Name of Medication (please print)	Dose	How often do you take it?	Continue After Discharge	Stop After Discharge

New Medications or New Dosages you should take after discharge

Name of Medication (please print)	Dose	How often to take	Continue After Discharge	Stop After Discharge

Signature of Patient/Responsible Person _____ **Date:** _____

☐ **Medication reconciliation reviewed verbally and a signed copy given to patient**

RN Signature _____ **Date/time:** _____
MD Signature_____ **Date/Time**_____

BERGEN-PASSAIC EYE SURGERY CENTER

PRE/POST OP ORDERS

Patient _____ **DOB** _____

Surgeon _____ **DOS** _____

Additional/Verbal Orders are to be written on reverse side

PRE-OP ORDERS

I. Have patient void, if needed, prior to entering preop area

II. Medications

1. ☐ Proparacaine 0.5% one drop to operative eye x 1 dose; Use first in series of drops

2. Antibiotics

- ☐ Ciprofloxacin 0.3% one drop to operative eye every 5 minutes x 3 doses
- ☐ Ofloxacin 0.3% one drop to operative eye every 5 minutes x 3 doses
- ☐ Tobramycin 0.3% one drop to operative eye every 5 minutes x 3 doses

3. Pupillary dilation drops ☐ Yes ☐ No **If yes,** following antibiotic drops ordered above

- ☐ Tropicamide 1% (1) gtt given to operative eye every 5 minutes x 3 doses
- ☐ Phenylephrine 2.5% (1) gtt given to operative eye every 5 minutes x 3 doses
- ☐ Phenylephrine 10.0% (1) gtt given to operative eye x 1 dose
- ☐ Cyclopentolate 1% (1) gtt, three doses given to operative eye every 5 minutes x 3 doses
- ☐ Atropine 1% to operative eye x 1 dose

4. Other

- ☐ Pilocarpine 2% one drop to operative eye x 2 doses; 5 minutes apart
- ☐ Brimonidine 0.2% one drop to operative eye x 1 dose
- ☐ Prednisolone Acetate 1% one drop to operative eye x 1 dose
- ☐ Acetazolamide 250mg Tab PO x 1 dose
- ☐ Flurbiprofen 0.03% one drop to operative eye x 1 dose
- ☐ _____

Surgeon request for type of Anesthesia

OR Procedures

- ☐ Start saline lock
- ☐ Peribulbar Block Honan
- ☐ IV Sedation
- ☐ Retrobulbar Block
- ☐ Yes
- ☐ Topical
- ☐ No

Laser Procedures

- ☐ Topical anesthetic eye drops only

Signature **Date**

POST-OP ORDERS

- ☐ Diet: Resume normal diet
- ☐ Discontinue saline lock when patient tolerates PO fluids
- ☐ Brimonidine 0.2% one drop to operative eye x 1 dose
- ☐ Prednisolone Acetate 1% one drop to operative eye x 1 dose
- ☐ Acetazolamide 250mg Tab PO x 1 dose

Activity: ☐ Return to preoperative activity ☐ Other _____

Medications: ☐ Resume normal medications ☐ Other _____

Return to the doctor's office on _____

Other instructions _____

☐ Discharge home when patient is alert, tolerating PO fluids and vital signs in expected range

_____

Signature **Date**

Date _____

Dear Doctor_____,

Thank you for seeing our mutual patient _____
(print patient name)

who is scheduled for the following ophthalmic surgery _____
(print name of surgical procedure)

with Dr _____ on _____.
(print name of surgeon) (print date)

Bergen-Passaic requires a comprehensive History and Physical (H&P) within 30 days of the date of surgery for **all** surgical procedures.

The necessity of lab work and/or an EKG is dependent on your determination of required pre-op testing based on the patient's health status. None are required if the patient is stable and there is no change in health status.

Please indicate to your patient whether to take all medications as prescribed, including anticoagulants. On the day of surgery, the patient may continue taking all medications as per your direction except insulin or oral diabetes medications. Please provide a complete list of all medications including dosage for your patient.

All paperwork must be received by the surgery center **5 business days** prior to the date of surgery and should clearly list the patient's name and the date of the examination or test. For your convenience, a copy of the surgery center's H&P form is enclosed. Please return the completed form via mail or fax to:

Bergen-Passaic Eye Surgery Center
18-01 Pollitt Drive, Suite 4
Fair Lawn, NJ 07410
Phone: (201) 414-5649 | Fax: (201) 398-9132

If you find that there are physical conditions requiring either a postponement or a cancellation of surgery, please notify the surgery center's scheduling coordinator immediately at ext 1115.

Thank you for your cooperation.

Sincerely,
The Bergen-Passaic Eye Surgery Center Staff

BERGEN-PASSAIC EYE SURGERY CENTER

HISTORY AND PHYSICAL

Patient _____ Date _____

Date of Birth _____ Age _____ Sex _____ MR# _____

Procedure _____ Diagnosis _____ Surgeon _____

Vital Signs B/P _____ Pulse _____ Resp _____ Temp _____ Ht _____ Wt _____

HISTORY

Medical History
Surgical History
Family History
Allergies
Medications (Please provide a complete list of medications including dosage)

PHYSICAL EXAM	**Normal (✓)**	**Comments/Abnormal Findings**
General		
Skin		
Eyes		
ENT		
Respiratory		
Cardio Vascular		
Abdomen/GI		
GU		
Neurologic		
Mental Status		

Impressions

Pregnancy test performed for female patient of childbearing years (18-50)? ☐ Yes ☐ No Result _____

Patient is cleared for surgery in an ambulatory setting ☐ Yes ☐ No

_____ _____

Physician Signature Date

BERGEN-PASSAIC EYE SURGERY CENTER

OCULAR HISTORY

Patient: _____ DOB: _____

HISTORY □ Blurry Vision □ Glare □ Difficulty Viewing Television
□ Difficulty Seeing Traffic/Road Signs □ Difficulty Reading Fine Prints/Labels
□ Impaired Depth Perception □ Difficulty Recognizing Faces
Other_____ Tensions T_A _____

OCULAR EXAM

Visual Acuity: 20/_____OD 20/_____OS

Glare Acuity: 20/_____OD 20/_____OS
(If Applicable)

SLE □ Immature Cataract □ PSC □ Nuclear Sclerosis
□ Mature □ Cortical □ Posterior Polar

□ Other: _____

Fundus □ Normal □ Other _____

Ocular Meds/Dosage _____

Allergies:_____ Mental Status: _____ Other: _____

Diagnosis: _____

Plan: _____

Risk of Complication: *Explained to patient and documented*

Post Operative Plan – See patient postoperatively within 24 hours of surgery. Patient to receive postoperative instructions for care and precautions of the eye from the Surgery Center, which were adopted by the medical staff of Bergen-Passaic Cataract Surgery and Laser Center, Inc. A copy of these instructions is maintained in the policy and procedure manual of the Bergen-Passaic Eye Surgery Center.

_____
Surgeon Signature

BERGEN-PASSAIC
CATARACT SURGERY & LASER CENTER, INC

IOL DIOPTER

Patient: _____ DOB: _____ MR#_____

Surgeon: _____ DOS: _____

ANTERIOR STYLE

MFR	LENS MODEL	DIOPTER
ALCON		
	☐ MTA3UO	_____
	☐ MTA4UO	_____
	☐ MTA5UO	_____
	☐ _____	_____

POSTERIOR STYLE

MFR:	LENS MODEL	DIOPTER
ALCON		
	☐ SY60WF	_____
	☐ CC60WF (CLEAR)	_____
	☐ MA60AC	_____
	☐ CNWETO (VIVITY)	_____
	☐ CCWETO (VIVITY CLEAR)	_____
	☐ CNWET (VIVITY TORIC) _____	_____
	☐ CCWET (VIVITY TORIC CLEAR)	_____
	☐ CNWTTO (PANOPTIX)	_____
	☐ CCWTTO (PANOPTIX CLEAR)	_____
	☐ CNWTT (PANOPTIX TORIC) _____	_____
	☐ CCWET (PANOPTIX TORIC CLEAR) _____	_____
	☐ CCW0T (CLAREON TORIC CLEAR) _____	_____
	☐ OTHER	_____

MFR:	LENS MODEL	DIOPTER
J&J		
	☐ ZCBOO	_____
	☐ DIBOO	_____
	☐ ZA9003	_____
	☐ DIU (EYEHANCE TORIC)	_____
	☐ DFR00V (SYNGERY)	_____
	☐ DFW (SYNERGY TORIC) _____	_____
	☐ DXR (SYMFONY OPTIBLUE)	_____
	☐ DXW (SYMFONY OPTIBLUE TORIC) _____	_____
	☐ ZCU (MONOFOCAL TORIC) _____	_____
	☐ AR40M (SENSAR 3 PIECE)	_____
	☐ OTHER	_____

B&L		
	☐ MX60E	_____
	☐ MX60ET____	_____
	☐ OTHER	_____

OTHER LIST MANUFACTURER		
☐	_____	_____

☐ RIGHT EYE -OD ☐ LEFT EYE-OS

IOL MASTER ☐ YES ☐ NO

☐ TOPICAL ☐ BLOCK ☐ TEMPORAL ☐ SUPERIOR ☐ ORA ☐ FEMTO

☐ LRI ☐ GONIOTOMY ☐ I-STENT ☐ XEN GEL ☐ TRYPAN ☐ CTR

☐ IRIS HOOKS ☐ MALYUGIN RING ☐ EPI-MIX ☐ DEXTENZA ☐OMIDRIA ☐ _____

_____ _____

Surgeon/Ophthalmic Technician Signature Date

BERGEN-PASSAIC
CATARACT SURGERY & LASER CENTER, INC

Hardship Application

Patient Name: _____

As a courtesy Bergen-Passaic Cataract Surgery and Laser Center, Inc may extend "*Hardship*" status to a patient, who does not have the resources to pay. "*Hardship*" status is based upon the Federal Poverty Guidelines.

Medicare Statement: Bergen-Passaic accepts assignment on all Medicare procedures, which means that Bergen- Passaic accepts the Medicare approved amount for services rendered. Medicare typically pays 80% of the approved amount. By law, a provider who accepts Medicare must attempt to collect the balance from the patient, either directly or through supplemental insurance. If the patient does not have the resources to pay this balance hardship status may be extended to the patient.

In order to determine "Hardship" status for a patient the following information must be completed in its entirety and returned to the center.

Financial Information:

Current Monthly Income: $_____ OR Previous Full Year Income: $_____

Please include all financial information such as: Wages, Social Security, Pension, Disability, etc. If the patient is married all spousal financial information must be included. Bergen-Passaic reserves the right to request proof of the above entered information; including any and all supporting documentation.

Insurance Information:

Do you have insurance? □ Yes □ No If yes please provide the following information:

Primary Insurance Company Name	Phone Number
Address	
Policy Holder	Relationship to Patient
ID#	Date of Birth
Secondary Insurance Company Name	Phone Number
Address	
Policy Holder	Relationship to Patient
ID#	Date of Birth

Patient Statement:

I certify that the above information is correct and that I allow Bergen-Passaic Cataract Surgery and Laser Center, Inc to verify this information. Furthermore my current resources prevent me from paying my balance and I request that Bergen-Passaic Cataract Surgery and Laser Center, Inc grant me "Hardship" status.

_____ _____ _____

Patient or Power of Attorney Signature | Printed Name | Date

This form fulfills the Center's requirement of maintaining proper documentation for any patient qualifying for *"Hardship"* status.

Your surgery will be scheduled at Bergen-Passaic Eye Surgery Center, located at 18-01 Pollitt Drive, Suite 4, Fair Lawn, NJ 07410.

The staff at Bergen-Passaic will do their utmost to make your experience comfortable. The following information is for you to review prior to arrival.

Should you have any questions regarding its content you may call the surgery center directly at (201) 414-5649.

Directions

From Routes 4, 17, 80 West & the Garden State Parkway Take exit for Route 4 West toward Paramus. Route 4 divides stay to the right and continue on Route 208 North to the McBride Ave Exit. Make the first right turn onto Pollitt Dr. 18-01 Pollitt is a one-story commercial building on the left. Continue past the building and around the corner. Make a left into the first driveway. The surgery center entrance is located under the southernmost canopy (the first canopy as you enter the parking lot)

From Route 287 North and South Take Route 287 to Route 208 South. Take the Fair Lawn Ave Exit. At the light at the top of the exit ramp turn left onto Fair Lawn Ave. Turn left onto the ramp for RT-208 North. Follow directions from Route 208 North above.

From 80 East Take I-80 E toward New York. Take Exit 60 for State Hwy 20 N toward Hawthorne. Merge onto McLean Blvd/RT-20N. Turn right at the Fair Lawn Avenue Bridge onto Fair Lawn Avenue. Proceed approximately ¾ mile. Turn left onto the ramp for RT 208 North. Follow Directions from RT 208 North above.

Interpretation/Translation Services

The Bergen-Passaic Eye Surgery Center utilizes an interpretation/translation service, which has availability of over 150 languages. Please advise the center if interpretation/translation services are needed.

Advance Directive Policy

The Bergen-Passaic Eye Surgery Center does not administer general anesthesia. The State of New Jersey provides for an advance directives requirement only when general anesthesia is administered. However, under Medicare requirements, this facility must provide you the patient or, as appropriate, the patient's representative, in advance of the date of the procedure, with information concerning its policies on advance directives, including a description of applicable State health laws and, if requested, official State advance directive forms.

This facility's policy is to inform patients about State advance directives requirements, and when one is presented, to ensure that its terms are discussed by the patient, the patient's representatives when applicable, and the doctors involved in the patient's care. This will be discussed with you by your surgeon it in advance of the surgery date. The surgeon will inform you that, because we cannot diagnose or identify prognoses beyond our surgical capabilities, we cannot honor the advance directive at this facility, and regardless of its provisions, in the unlikely event of an emergency, you will be resuscitated and transferred to a hospital.

This initial advance directive discussion will take place between you and your surgeon in the surgeon's office in advance of the date of surgery. Should you request advance directive information, it will be provided at that time.

Under New Jersey Law, treatment can be withheld or withdrawn in accordance with an Advance Directive. There is no specific form of Advance Directive that must be followed in New Jersey. You don't need a lawyer to prepare an Advance Directive. It can be as simple as a letter stating your health care wishes or naming the person you trust to make health care decisions for you. There are many sources for information about Advance Directives. The New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care prepared a booklet that is available on-line at www.state.nj.us/health/ltc/advance_directives.pdf.

BERGEN-PASSAIC EYE SURGERY CENTER

Patient Rights and Responsibilities

1. The patient has the right to considerate and respectful care given by competent personnel, free from all forms of abuse and/or harassment as well as any act of discrimination or reprisal.

2. The patient has the right, upon request, to be given the name of his attending practitioner, the names of all other practitioners participating in his care, and the names and functions of other health care persons having direct contact with the patient.

3. The patient has the right to consideration of his/her privacy concerning his/her own medical care program. Case discussion, consultation, examination, and treatment are considered confidential and should be conducted discretely.

4. The patient has the right to have records pertaining to his/her medical care treated as confidential, except as otherwise provided by law or third party contractual arrangements.

5. Patients have the right to know what facility rules and regulations apply to their conduct as a patient, including information on Advance Directives, and facility policy on Advance Directives.

6. Patients have the right to expect emergency procedures to begin without unnecessary delay.

7. The patient has the right to good quality care and high professional standards that are continually maintained and reviewed, and to expect and receive appropriate assessment, management, and treatment of pain as an integral component of care in accordance with N.J.A.C. 8:43E-6.

8. The patient has the right to full information in layman's terms concerning his/her diagnosis, treatment, and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give such information to the patient, the information shall be given on his behalf to a responsible person.

9. Except for emergencies, the practitioners shall obtain the necessary informed consent prior to the start of the procedure.

10. A patient, or if the patient is unable to give informed consent, a responsible person, has the right to be advised when practitioner is considering the patient as part of a medical care research program or donor program, and the patient or responsible person, shall give informed consent prior to actual participation in the program. A patient, or responsible person, may refuse to continue in a program to which he has previously given informed consent.

11. The patient has the right to refuse drugs or procedures, to the extent permitted by statute, and a practitioner shall inform the patient of the medical consequences of a refusal of drugs or procedures.

12. A patient has the right to medical and nursing services, without discrimination or reprisal based upon age, race, color, religion, sex, national origin, handicap, disability, or source of payment.

13. A patient who does not speak English shall have access, where possible, to an interpreter.

14. The facility shall provide the patient, or patient designee, upon request, access to the information contained in his medical records, unless access is specifically restricted by the attending practitioner for medical reasons.

15. The patient has the right to expect good management techniques to be implemented within this surgery center. These techniques shall make effective use of the time of the patient and avoid the personal discomfort of the patient.

16. When an emergency occurs and the patient is transferred to another facility, the responsible person shall be notified. The institution to which the patient is to be transferred shall be notified prior to the transfer.

17. The patient has the right to examine and receive an explanation of his/her bill.

18. The patient has the right to expect that the surgery center will provide information for continuing health care requirements following discharge and the means for meeting them.

19. Patients have the right to be informed of these rights, ownership of the facility by their doctor, privacy policies, and policies on Advance Directives, prior to the procedure.

20. The patient has the right to obtain information as to any relationship of the facility to other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him/her, and to receive information on physician ownership of the facility.

21. The patient has the right to make recommendations or lodge a complaint about any aspect of care. The patient may make a complaint to the Center's Administrator, Caroline Ivanovski-Hauser, at (201) 414-5649. The patient may also file a complaint with the NJ Department of Health and Senior Services at their Complaints Hotline, (800) 792-9770, and on line at www.doh.state.nj.us/fc; or with the Office of the Medicare Beneficiary Ombudsman, www.medicare.gov/ombudsman; or with the Accreditation Association for Ambulatory Health Care (AAAHC) at (847) 853-6060.

In addition, this facility's patients have an obligation to conduct themselves appropriately and provide sufficient information to the facility's staff to facilitate their own care. Accordingly, this facility also adopts a statement of Patient Responsibilities:

1. The patient is responsible for informing the surgery center staff of any changes in their health status that could affect their treatment.

2. The patient is responsible for adhering to the prescribed treatment plan and/or advising the surgery center staff of any intention/desire not to adhere to the prescribed treatment plan.

3. The patient is responsible for asking questions and seeking clarification regarding areas of concern.

4. The patient is responsible for completing any health status questionnaires requested by the Surgical Institute. The patient will supply current and accurate information about allergies, and a complete list of medications taken and dosages.

5. The patient is responsible for acting in a considerate and respectful manner with health center staff.

6. The patient is responsible for informing the facility of the existence of an advance directive, if the directive would influence care decisions.

7. The patient is responsible for keeping their scheduled appointments. Patients are responsible for ensuring that they are accompanied by a responsible adult at discharge, unless exempted by the surgeon, who will accompany the patient from this facility, and who will stay with the patient for 24 hours after surgery if required by the patient's physician.

8. The patient is responsible for notifying the surgery center in the event they are unable to keep an appointment, and to be accompanied by a responsible adult on the day of surgery, unless exempted by the attending physician.

9. The patient is responsible for reading information provided by health center staff, following the instructions contained in the written materials, and completing quality of care questionnaires.

10. The patient is responsible for providing complete and accurate insurance verification information on all possible insurance payers, and when deductibles and co-pay amounts are due, for paying those fees and charges associated with surgery center services. Self-pay patients are responsible for payments as agreed upon before surgery.

NOTICE OF PRIVACY PRACTICES

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.

I. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

You have come to Bergen-Passaic Eye Surgery Center (the "Surgery Center") to have surgery done at our ambulatory surgical facility. Since medical information will be obtained and recorded about you as part of your procedure, this Notice of Privacy Practices describes how your medical information may be used and disclosed by the Surgery Center and how you can get access to, and control, this information in some cases. The medical information described below that is subject to the Surgery Center's Privacy Practices, is called protected health information or PHI for short. PHI includes information that can be used to identify you that we either have created or received about your past, present, or future health or condition, the provision of health care to you or the payment of this health care.

We must provide you with this Notice about our privacy practices that explains how, when and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices described in this Notice. However, we reserve the right to change the terms of this Notice and our privacy practices at any time as described below in Section IV.

II. USES AND DISCLOSURES WE MAY MAKE OF YOUR PHI

1. Uses and Disclosure The Surgery Center uses and discloses PHI for many different reasons. Different categories of uses and disclosures are described below with some examples in each category. Your PHI may be used and disclosed by the Surgery Center, without any specific authorization by you, in connection with your treatment, payment or the health care operations of the Surgery Center. It may also be used by our "business associates", which are generally companies that perform various services for the Surgery Center, like submitting bills to Medicare and insurance carriers on behalf of the Surgery Center, to perform their own obligations to us, for their own proper management and administration, and to carry out their legal obligations or for certain data aggregation purposes. These business associates are limited by federal privacy

rules in disclosing your health information to the same extent that the Surgery Center would be limited, with certain exceptions.

Examples:

Treatment: As part of your treatment at the Surgery Center, your PHI may be used and disclosed among health care professionals without any specific authorization from you. For example, medical information about a prior eye operation, or about your reaction to certain drugs, or an allergic condition, or a physical ailment revealed in your history and physicals examination may be shared with your Eye Surgeon or employees in his medical offices, the nurses at the Surgery Center, and the anesthesiologist contracted with to provide anesthesia services to you. This information may be shared with health care professionals in connection with your treatment at the Surgery Center.

Payment: In order to obtain payment of our facility fees, the Surgery Center may use your PHI for billing and disclose it to your insurance carrier, or to Medicare, or to your health plan, without any specific authorization from you. For example, billing information will be submitted to your insurance carrier, or Medicare, with certain codes reflecting the procedure that was performed on you at the Surgery Center. Information from your health care plan may be sought to determine your eligibility in the plan, or an approval for the medical procedure, which will require disclosure of the surgical procedure to be performed and/or medical information about you involving this procedure from the medical records we may have available to us. This information will be disclosed to our management company, as well, which performs billing services for the Surgery Center. It may also be disclosed to another provider involved in your care such as the anesthesiologist, or his staff, so that he can perform his own billing for the medical procedure involved.

Health Care Operations: Without your specific authorization, we may also use or disclose your PHI as part of our health care operations. This would include such things as evaluating the quality of health care services you received at the Surgery Center, evaluating the performance of health care professionals who provided these health care services to you, case management, training programs, accreditation, licensing and credentialing activities. For example, your PHI may be used as part of a quality assessment review regarding similar procedures performed by your surgeon, or all surgeons, at the Surgery Center and the results, or it may be disclosed to our Medical Director or medical governing body so that an evaluation of health care services can be conducted, or PHI may be disclosed to an accrediting body in order for the Surgery Center to maintain or renew its accreditation. Your PHI may also be used or disclosed as part of a population-based study aimed at improving health care or reducing health care costs, such as a study relating to the use of certain intraocular lenses in cataract surgery and the outcome of such use over a given period. As part of our health care operations, disclosures of your medical

information may therefore be made to bodies or groups like our medical governing body, our Medical Director, our management company, or a licensing or accrediting body like AAAHC or the New Jersey State Department of Health.

2. Other Uses and Disclosures We may also use and disclose your PHI without your specific authorization for the following reasons.

A. **Treatment** As part of treatment and without your specific authorization, we may also disclose your medical information to other health care professionals, such as an optometrist who may be treating you following surgery, or to a retina specialist or other eye care professional. We may also contact you to remind you about a scheduled surgery, or, through our nursing staff, we may follow up to inform you about drugs, and dosages, that your surgeon has prescribed following your surgery.

B. **Payment** As part of payment, we may provide an operative report to your health plan regarding your surgery to show complications and in order to obtain payment for the amount billed. We may also disclose your PHI to our attorneys, or even a collection company, to assist us in obtaining payment of the facility fees billed by the Surgery Center. We may also provide your PHI to other health care professionals involved in your treatment, or to a group or company regulated under the HIPAA privacy rules, to assist them with billing.

C. **Health Care Operations** As part of our health care operations, disclosures of your PHI may be made to bodies or groups like our medical governing body, our Medical Director, our management company, or a licensing or accrediting body like AAAHC or the New Jersey State Department of Health. Your medical information may also be disclosed under certain circumstances to another group or company, that is regulated under the HIPAA privacy rules, for the health care operations of that group or company including purposes involving health care fraud and abuse detection and compliance efforts.

D. **Business Associates** Our business associates perform certain services for the Surgery Center. They include our management company, computer software companies, attorneys, accountants, medical transcription services and others, who will be exposed to your medical information. These business associates may not use or disclose such medical information if it would amount to a violation of the federal privacy rules if the Surgery Center used or disclosed it, with certain exceptions.

E. **Uses and Disclosures Required by Law** The Surgery Center may use or disclose your PHI where such use or disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of the law in question. For example, we may make disclosure of your PHI when the law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence. We may also

disclose your PHI when ordered in a judicial or administrative proceeding. We may also disclose your PHI in response to a subpoena, discovery request or other lawful process, without a court order or order from an administrative tribunal, if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. **Uses and Disclosure for Public Health Activities** The Surgery Center may disclose a patient's PHI for certain public health activities and purposes. For example, we may report information about various diseases or injuries to government officials in charge of collecting that information, and we may provide coroners, medical examiners, and funeral directors information relating to an individual's death. Some other public health purposes include a public health investigation or surveillance, reporting an adverse event or product defect or notifying someone exposed to a communicable disease or who may be at risk or spreading a disease, as authorized by law.

G. **Appointment Reminders/Medications** We may use PHI to remind you about a scheduled surgery, or, through our nursing staff, we may follow up to inform you about drugs, and dosages, that your surgeon has prescribed following surgery.

H. **Disclosures about Victims of Abuse, Neglect or Domestic Violence** The Surgery Center may disclose PHI about a patient whom it reasonably believes to be the victim of abuse, neglect or domestic violence to a government authority including a social services agency authorized by law to receive such reports. The disclosure must be required by law and limited to the relevant requirements of such law. If the Surgery Center makes such a disclosure, it will promptly inform the person that such a report has been or will be made except where the Surgery Center believes informing the person would place him or her at risk of serious harm or where we would be informing a personal representative whom the Surgery Center reasonably believes is responsible for the abuse, neglect or other injury.

I. **Uses and Disclosures for Health Oversight Activities** The Surgery Center may disclose a patient's PHI to a health oversight agency for oversight activities authorized by law or other activities necessary for appropriate oversight of the health care system, government benefit programs, or for purposes of determining compliance. For example, we may provide information to a governmental agency when it conducts an investigation or inspection of the Surgery Center or another health care provider or organization.

J. **Disclosures for Law Enforcement Purposes** Under specified conditions, the Surgery Center may disclose a patient's PHI for a law enforcement purpose to a law enforcement official. This may involve a court order or a subpoena. The Surgery Center may also disclose PHI in response to a law enforcement official's request under certain circumstances.

K. **Uses and Disclosures to Avert a Serious Threat to Health or Safety** The Surgery Center may disclose a patient's PHI to law enforcement personnel or persons able to prevent or lessen harm where there is a serious threat to the health or safety of a person or the public.

L. **Uses and Disclosures for Specialized Government Functions** The Surgery Center may disclose PHI of military personnel and veterans in certain situations. In addition, the Surgery Center may also disclose a patient's PHI to authorized federal officials for the conduct of lawful intelligence, and other national security activities. The Surgery Center may also disclose a patient's PHI to a correctional institution or law enforcement official with custody of an inmate under certain situations.

M. **Disclosures for Workers' Compensation Purposes** The Surgery Center may also disclose a patient's PHI in order to comply with workers compensation or similar programs that provide benefits for work related injuries or illness.

N. **Disclosures for Organ Donation** We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.

USES AND DISCLOSURES THAT REQUIRE YOU TO HAVE AN OPPORTUNITY TO OBJECT

Disclosures to Family, Friends and Others If the patient is present and is competent to make health care decisions, and does not object by his signature below, the Surgery Center may disclose to a family member, other relative, or close personal friend of the patient, or any other person identified by the patient, PHI of the patient directly relevant to the person's involvement with the patient's care or payment relating to such care.

Unless an objection is indicated by a signature below if the patient is present and is competent to make health care decisions, the Surgery Center may also use or disclose PHI to notify, or assist in notifying, a family member, personal representative of a patient, or another person responsible for the care of the patient of the patient's location, general condition or death.

Objection to disclosure to family member etc and in notifying family member

_____

Sign Here

Agreement to disclose to family member etc and in notifying family member

_____

Sign Here and indicate any limitations

If the patient has not signed above, agreeing to a disclosure or objecting to same, because of incapacity or an emergency circumstance, the Surgery Center, in our judgment, will determine whether or not disclosure is in the patient's best interests and will only disclose information that is directly relevant to the person's involvement with the patient's health care.

3. **Uses and Disclosures Requiring Authorization** Except for the uses and disclosures of a patient's PHI permitted as stated in this Privacy Notice, all other uses and disclosures by the Surgery Center of a patient's PHI will be made only with the patient's written authorization which the patient may revoke at any time upon giving written notice of such revocation to the Surgery Center. An authorization is a separate document which provides for additional uses and disclosures of a patient's medical information.

III. INDIVIDUAL RIGHTS OF PATIENTS

A patient has the right to request restrictions on certain uses and disclosures of his PHI, including uses or disclosures to carry out treatment, payment or health care operations. While the patient may request such restrictions, the Surgery Center is not legally required to agree to any such restriction but we will consider your written request. Your request must state the specific restriction requested and should state to whom you want the restriction to apply. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

With respect to his or her PHI, a patient has the following rights:

1. **The right to inspect and copy his or her PHI.** In most cases, you have the right to look at or get copies of your PHI that we have. The request must be made in writing and we will either permit visual inspection at the Surgery Center within 60 days after receiving your request or we will provide a copy within 60 days after receiving your request. If we don't have your PHI but know who does, we will tell you how to get it. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reason for the denial and your right to have the denial reviewed. To inspect and copy your PHI, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your PHI, we may impose a reasonable charge.

2. **The right to correct or update his or her PHI.** If you believe there is a mistake in your PHI or important information is missing, you have the right to request that we correct the existing information or add the missing information. The request and the reason for the request must be in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is correct and complete, or was not created by us, or is not part of our records or is not available for inspection under the HIPAA privacy rules. If the request is denied, we will

explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI.

3. The right to receive a list of disclosures we have made. You have a right to get a list of instances in which we have disclosed your PHI. The list will not include uses and disclosures of your PHI that we may make for treatment, payment or health care operations, disclosures directly to you, or your family or persons involved in your care, for the Surgery Center's directory, or disclosures that have been authorized by you in writing under HIPAA's privacy rules. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel or before April 14, 2003. We will respond within 60 days after receiving your request. The list we will give you will include disclosures made in the last 6 years unless you request a shorter time. The list will include the date of the disclosure, to whom the PHI was disclosed (including an address if known), a description of the information disclosed and the purpose for the disclosure.

4. The right to make a reasonable request that we send your PHI by alternative means or at an alternative location. You have the right to request that we send information to you at an alternate address (a PO box or a work address rather than your home address) or by a different means (such as e mail instead of regular mail). The request should be submitted in writing to the Surgery Center's Privacy Officer at the address set forth below. We will accommodate reasonable requests.

5. The right to obtain a copy of this paper notice upon request. Even if you have agreed to get a copy of this Notice by e mail, you have a right to request a paper copy of this Notice. The above rights may be exercised by writing to the Surgery Center, via certified mail, addressed to: Bergen-Passaic Eye Surgery Center, Attn: Privacy Officer, 18-01 Pollitt Drive, Suite 4, Fair Lawn, NJ 07410.

IV. THE SURGERY CENTER'S DUTIES

The Surgery Center is required by law to maintain the privacy of a patient's PHI and to provide patients with notice of its legal duties and privacy practices with respect to such information. The Surgery Center is required to abide by the Notice of Privacy Practices that is currently in effect although it may change or revise its Notice of Privacy Practices, from time to time. The Surgery Center reserves the right to change the terms of its Notice of Privacy Practices and to make the new Notice provisions effective for all patient PHI that it maintains including PHI created or received prior to the change in the Surgery Center's Notice of Privacy Practices. Such revised notice will be available to patients by posting such revised Notice at the Surgery Center's facility, currently 18-01 Pollitt Drive, Suite 4, Fair Lawn, NJ 07410, and a patient may also request a copy

of the revised notice by writing to the Surgery Center, Bergen-Passaic Eye Surgery Center, Attn: Privacy Officer, 18-01 Pollitt Drive, Suite 4, Fair Lawn, NJ 07410, or by calling the Surgery Center's Privacy Officer, at (201) 414-5649.

V. COMPLAINTS

If a patient believes his privacy rights have been violated, he or she may complain to the Surgery Center and to the Secretary of the Department of Health and Human Services. You may file a complaint with the Surgery Center by writing to the Surgery Center, via certified mail, addressed to Bergen-Passaic Eye Surgery Center, Attn: Privacy Officer, 18-01 Pollitt Drive, Suite 4, Fair Lawn, NJ 07410. A patient will not be retaliated against for filing a complaint.

VI. FURTHER INFORMATION

For further information about the Surgery Center's Privacy Policies or anything related contained in this Notice, you may contact Bergen-Passaic Eye Surgery Center, Attn: Privacy Officer, 18-01 Pollitt Drive, Suite 4, Fair Lawn, NJ 07410, (201) 414-5649.

VII. EFFECTIVE DATE

This Notice is effective on July 1, 2009.