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, John Cabrera, 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.

Provider Notice of Privacy Practices

NOTICE FOR MEDICAL INFORMATION: 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.

Medical Information Privacy Notice

Effective January 1, 2019

We are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, and if we maintain a website, we will post a copy of the revised notice on our website scasurgery.com. If we maintain a physical delivery site, we will also post a copy in at our office. The notice will also be available upon request. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and

To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to bill for your health care and to operate our business. For example, we may use or disclose your health information:

For Payment. We may use or disclose health information to obtain payment for health care services. For example, we may disclose your health information to your health plan in order to obtain payment for the medical services we provide to you. We may ask you for advance payment.

For Treatment. We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

For Health Care Operations. We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care. For example, we might analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, it is no longer subject to this notice and we may use it for any lawful purpose.

To Provide You Information on Health Related Programs or Products such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.

For Reminders. We may use or disclose health information to send you reminders about your care, such as appointment reminders with providers who provide medical care to you or reminders related to medicines prescribed for you.

We may use or disclose your health information for the following purposes under limited circumstances:

As Required by Law. We may disclose information when required to do so by law.

To Persons Involved With Your Care. We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

For Public Health Activities such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.

For Reporting Victims of Abuse, Neglect or Domestic Violence to government authorities that are authorized by law to receive such information, including a social service or protective service agency.

For Health Oversight Activities to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.

For Judicial or Administrative Proceedings such as in response to a court order, search warrant or subpoena.

For Law Enforcement Purposes. We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

To Avoid a Serious Threat to Health or Safety to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

For Specialized Government Functions such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

For Workers' Compensation as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.

For Research Purposes such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.

To Provide Information Regarding Decedents. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

For Organ Procurement Purposes. We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.

To Correctional Institutions or Law Enforcement Officials if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for

the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

To Business Associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and permitted by law.

Additional Restrictions on Use and Disclosure. Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

1. Alcohol and Substance Abuse
2. Biometric Information
3. Child or Adult Abuse or Neglect, including Sexual Assault
4. Communicable Diseases;
5. Genetic Information
6. HIV/AIDS
7. Mental Health
8. Minors Information
9. Prescriptions
10. Reproductive Health
11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out how to revoke an authorization, use the contact information below under the section titled "Exercising Your Rights."

What Are Your Rights

The following are your rights with respect to your health information:

You have the right to ask to restrict uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction other than with respect to certain disclosures to health plans as further described in this notice.

You have the right to request that we not send health information to health plans in certain circumstances if the health information concerns a health care item or service for which you or a person on your behalf has paid us in full. We will agree to all requests meeting the above criteria and that are submitted in a timely manner.

You have the right to ask to receive confidential communications of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

You have the right to see and obtain a copy of certain health information we maintain about you such as medical records and billing records. If we maintain a copy of your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect or obtain a copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

You have the right to ask to amend certain health information we maintain about you such as medical records and billing records if you believe the information is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on our website, scasurgery.com by calling SCA's Privacy Officer at (205) 545-2713.

Exercising Your Rights

• Contacting your Provider. If you have any questions about this notice or want information about exercising any of your rights, please call SCA's Privacy Officer at (205) 545-2713.

• Submitting a Written Request. You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

Privacy Officer
Surgical Care Affiliates
569 Brookwood Village, Suite 901
Birmingham, AL 35209
Telephone: (205) 545-2713
E-mail: privacy.officer@scasurgery.com

•Filing a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

Privacy Officer
Surgical Care Affiliates
569 Brookwood Village, Suite 901
Birmingham, AL 35209
Telephone: (205) 545-2713
E-mail: privacy.officer@scasurgery.com

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.