

**SPECTRA EYE INSTITUTE
9849 W. THUNDERBIRD
SUN CITY, ARIZONA 85351
(623) 583-2020**

Welcome! You have been scheduled to have surgery performed at Spectra Eye Institute. In order to comply with Medicare Guidelines we are required to supply you with this packet of information in advance to your surgery. Please see below the list of forms that are attached and sign at the bottom of this page acknowledging receipt of these forms. Some of these forms require that you either fill them out or sign them. We ask that you do this prior to arriving to your surgery so that we may expedite the process of getting you checked in.

- Spectra Eye Institute Notice of Privacy Practices (HIPAA)
- Advance Directives: Decisions About Your Healthcare
- Spectra Eye Institute Policy on Advance Directives
- Patient Rights and Responsibilities
- Spectra Eye Institute Grievance Procedure
- Notice of Direct Interest (**Applicable for Owners Only**)
- Health and History Questionnaire
- Tuberculosis Questionnaire

Thank you and we look forward to treating you at our center. Should you have any questions, please feel free to contact us at (623) 583-2020 ext. 3.

I acknowledge that I am in receipt of the above listed forms prior to my surgery and understand that it is my responsibility to read through, fill out, and sign these forms.

Patient Printed Name

Date

Patient Signature

Welcome to

Spectra Eye Institute, LLC

Advanced Eye Care through Advanced Technology

Spectra Eye Institute is a private outpatient surgical center dedicated to total eye care with a personal touch. Our AAAHC Accredited and Medicare Certified facility is equipped with state-of-the-art equipment to provide comprehensive ambulatory ophthalmic surgery services, including laser treatment.

IMPORTANT INFORMATION

Date of Surgery: _____

Check-In Time: _____

*****PATIENT MUST PRESENT WITH A PHOTO I.D.
THAT INCLUDES CURRENT ADDRESS*****

SPECTRA EYE INSTITUTE, LLC
9849 W. Thunderbird Blvd
Sun City, Arizona 85351
623-583-2020



**ACCREDITATION
ASSOCIATION**
for AMBULATORY HEALTH CARE, INC.

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August 1, 2010

Dear Patients of Spectra Eye Institute:

We at Spectra Eye Institute, LLC are pleased to announce that we have recently been accredited for three years by the Accreditation Association for Ambulatory Health Care (AAAHC/Accreditation Association).

This is an important milestone in the continuing growth and success of our health care organization. Accreditation shows our commitment to providing the highest levels of quality care to our patients, and the same high level of conduct in our business practices. Accreditation by the AAAHC is proof of this commitment, and signifies that we have met the rigorous standards of a nationally recognized third party.

We are proud to have met the challenge of accreditation, and intend to consistently uphold the principles of quality improvement and patient care in the future.

If we can answer any further questions, please contact us at 623-583-2020.

Sincerely,


Daniel J. Briceland, M.D.
Medical Director

Admitting

Generally, you are asked to arrive one hour before your scheduled surgery time. Please check in at the reception desk upon arrival. To make your stay more comfortable, please follow these procedures:

1. Unless specified by your physician, do not eat or drink anything after midnight the night before your surgery. Your usual medication may be taken with a sip of water unless otherwise specified.
2. Bring the completed health history questionnaire that the doctor's office gave to you to your surgery. It is especially important to list all of your medications and the daily dosages.
3. **Bring your Medicare and/or other insurance cards.**
4. **Bring a photo ID that includes your current address.**
5. Bring a copy of your Living Will and/or Medical Power of Attorney, if you have one.
6. Leave all valuables and jewelry at home.
7. Wear loose-fitting clothing.
8. Please do not wear any facial or eye makeup on the day of your surgery.
9. You may leave your dentures and hearing aids in place.
10. Arrange for transportation home. A responsible adult will need to drive you home. This adult is welcome to wait in our lobby. Please tell this individual to be prepared to wait approximately 2-4 hours. **Please limit this to only one individual as we have limited space in our waiting area.** For your safety and comfort, we ask that you plan to have a responsible adult remain with you for several hours after your discharge.
11. *****The use of cell phones is prohibited inside our Facility*****

Your surgeon may request that you purchase a post-operative medication kit. **There is a charge for these medications as they are often not covered at the pharmacy by Medicare as well as some other insurance companies.**

You may request prescriptions for these medications rather than purchasing the post-operative kit from the facility. **Please indicate to the registration staff whether you would like to take the prescriptions with you to your pharmacy or purchase the medications at our facility.**

Insurance

We will be happy to assist you in filing the insurance claim for your surgery. In order to do this, we will need copies of your insurance cards.

Medicare Patients: We are an approved Medicare facility. Therefore, we will bill Medicare according to their allowable rates. As a Medicare Part B participant, you are only responsible for the annual deductible, the 20% of the charges, known as “co-insurance”, and any non-covered services. A Medicare supplement insurance policy may cover these charges. However, keep in mind that you are ultimately responsible for this portion of your charges.

Private Insurance Patients: If we have a contract with your insurance carrier, we will file the claim for you. Since we have no control over your policy limits, filing of your insurance claim does not relieve you of responsibility for the full charges.

Self-Pay Patients: If you do not have health insurance coverage, or if your insurance company will not cover your services at **Spectra Eye Institute**, payment for your surgery will be expected at the time of admission, unless prior arrangements have been made with our facility.

Pre-Op

Please wear a short-sleeved button down shirt / blouse.

A nurse will ask you about medication allergies and which medications you are taking. This will ensure that all medications you receive at Spectra Eye Institute are compatible with your own medications.

In the pre-operative area, we will begin monitoring your blood pressure, heart rate and rhythm, and oxygen saturation. An intravenous line, or “IV”, will be started so that the anesthesiologist can give you medication to help you relax during the eye block.

The eye block is performed by a staff anesthesiologist or your ophthalmologist. The purpose is to inject local anesthesia, or “numbing medication”, around the eye so that you will have no discomfort during your surgery. The eye block also acts to prevent you from moving your eye or closing your eyelid during surgery.

At the discretion of your ophthalmologist, you may receive medication in your IV, which will induce a light sleep while the eye block is being performed. You will wake up shortly after the injection and remain awake during the surgery. Most of our patients tell us that they do not remember having the injection at all. After the eye block, your ophthalmologist may request that a pressure device be placed on the eye.

Do not be alarmed if you are unable to see clearly or open your eye after the injection. This is normal.

IF YOU FEEL ANY DISCOMFORT DURING SURGERY, PLEASE LET US KNOW IMMEDIATELY.

Operating Room

When you are ready for surgery, you will be taken into the operating room. An anesthesiologist or operating room nurse will be present at your side and will monitor your heart rate, breathing, and blood pressure; and is also there to reassure you and give you full personal attention and care.

The operating room nurse will wash, or “prep”, your eyelid and face with antibacterial solution. Next, a sterile sheet will be placed across your face. A special, lightweight frame is placed on your upper chest under the drape to create a tent of fresh air for you to breathe during surgery.

At the completion of your surgery, you will be taken to the post operative area.

SPECTRA EYE INSTITUTE, LLC

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.

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

Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please contact our Privacy Officer whose contact information is listed on the last page of this Privacy Notice to obtain the appropriate form for exercising these rights.

The right to receive and we are required to provide you with a copy of this Notice of Privacy Practices – We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices.

The right to request a restriction on uses and disclosures of your protected health information – This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. In certain cases we may deny your request for a restriction.

The right to inspect and copy your protected health information – In most cases, you have the right to look at or get a copy of your health information. To inspect and copy your medical information, you must submit a written request to the Privacy Officer. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

The right to request to receive confidential communications from us by alternative means or at an alternative location – You may ask us to communicate with you confidentially by, for example, sending notices to an alternate address. Requests must be made in writing to our Privacy Officer.

The right to request amendments to your protected health information – This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

The right to receive an accounting of disclosures – This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our facility.

The right to designate a personal representative – This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

How We May Use or Disclose Protected Health Information

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our facility.

For Treatment – We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

For Payment – Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the procedure we have scheduled for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. We may also disclose patient information to another provider involved in your care for the provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

For Health Care Operations – We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of our facility and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

Special Uses and Disclosures – As part of treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes: to remind you of your surgery date, to inform you of potential treatment alternatives or options, to inform you of health related benefits or services that may be of interest to you.

Other Uses and Disclosures

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

Required by Law – We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

Public Health Activities – As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight – We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Research – We may use or disclose information for approved medical research.

Abuse or Neglect – We may disclose your protected health information to a public health authority by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings – We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement – Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths – We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies.

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

Specified Government Functions – In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

Worker's Compensation – Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally established programs.

Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgement, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

Uses and Disclosures that you Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

Our Duties

The facility is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by the terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the facility changes its Notice, we will post the revised Notice in the Lobby. You may also request a copy of our Notice at any time. For more information regarding our privacy practices, you may contact our Privacy Officer.

Complaints

You have the right to express complaints to the facility and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by sending it to:

**Spectra Eye Institute, LLC
9849 W. Thunderbird Blvd.
Sun City, AZ 85351**

The Privacy Officer can be contacted by telephone at 623-583-2020

This notice is effective April 14, 2003.

DECISIONS ABOUT YOUR HEALTH CARE

How you can plan for the future

with living wills and other health care directives

You are getting this information about your rights to make or control your own health care decisions, because of a 1991 federal law. We hope this information will help you. A description of this health care organization's policies about your right to make health care decisions must be given to you along with this information. You are also encouraged to talk with your family. Your doctor, and anyone else who could help you in these matters.

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Q. Who makes your health care decisions?

A. You do, if you can make and communicate them. Your doctors should tell you about the treatment they recommend, other reasonable alternatives, and important medical risks and benefits of that treatment and the alternatives. You have the right to decide what health care, if any you will accept.

Q. What happens if you become unable to make or communicate your health care decisions?

A. You can still have some control over your health care decisions, if you have planned ahead. One way to plan ahead is by making a health care directive which names someone to make these decisions for you, or which guides or controls these decisions. If you have not named someone in a health care directive, your doctors must seek a person authorized by law to make these decisions. A person who makes health care decisions for you is called a surrogate.

Q. What is a health care directive?

A. It is a written statement about how you want your health care decisions made. Under Arizona law, there are three common types of health care directives. They are:

A *health care power of attorney*, which is a written statement in which you name an adult to make health care decisions for you. That person will make health care decisions for you only when you cannot make or communicate such decisions. A *living will*, which is a written statement about health care you want or do not want that is to be followed if you cannot make your own health care decisions.

For example, a living will can say whether you would want to be fed through a tube if you were unconscious and unlikely to recover.

These directives, used separately or together, can help you say "yes" to treatment you want and "no" to treatment you don't want.

Q. Must your health care directives be followed?

A. Yes. Both health care providers and surrogates must follow valid health care directives

Q. Can you be required to make a health care directive?

A. No. whether you make a health care directive is entirely up to you. A health care provider cannot refuse care based on whether or not you have a health care directive.

Q. Can you change or revoke health care directives?

A. Yes. If you change or revoke a health care directive, you should notify every one who has a copy.

Q. Who can legally make health care decisions for you if you are unable to make your own decisions and if you have not made a health care power of attorney?

A. A court may appoint a guardian to make health care decisions for you. Otherwise, your health care provider must go down the following list to find a surrogate to make health care decisions for you:

1. Your husband or wife, unless you are legally separated.
2. Your adult child. If you have more than one adult child, a majority of those who are available.
3. Your mother or father.

4. Your domestic partner, unless someone else has financial responsibility for you.

5. Your brother or sister.

6. A close friend of yours. (Someone who shows special concern for you and is familiar with your health care views.)

If your health care provider cannot find an available and willing surrogate to make health care decisions for you, then your doctor can decide with the advice of an ethics committee or, if this is not possible, with the approval of another doctor.

You can keep anyone from becoming your surrogate by saying, preferably in writing, that you do not want that person to make health care decisions for you

A surrogate will not have the right to refuse the use of tubes to give you food or fluids unless:

- you have appointed that surrogate to make health care decisions for you in a health care power of attorney; or
- a court has appointed that surrogate as your guardian to make health care decisions for you; or
- you have stated in a health care directive that you do not want this specific treatment.

ADDITIONAL INFORMATION FOR ANYONE WHO ALREADY HAS OR WANTS TO MAKE A HEALTH CARE DIRECTIVE.

Q. What if you already gave a living will or other health Care directive?

A. A health care directive that was valid when made anywhere in the U. S. is valid under Arizona law. However, Arizona law changed on September 30, 1992, making new choices available to you. You should review your health care directives periodically and update them as needed

Q. Do you need a lawyer to make a health care directive?

A. No. Just be sure that your directive is valid under Arizona law.

Q. What does the law require for a health care directive after September 30, 1992?

A. A health care power of attorney must:

- Name a person to make health care decisions for you if you become unable to make your own decisions. You may also name an additional person or persons to make decisions for you if your first choice cannot serve. The person or persons must be at least 18 years old.
- Be signed or marked by you and dated.
- Be signed by a notary or by an adult witness or witnesses, who saw you sign or mark the document and who say that you appear to be of sound mind and free from duress. A notary or witness cannot be the person you name to make your decisions and cannot be providing health care to you. If you have only one witness, that witness cannot be related to you or someone who will get any of your property from your estate if YOU died.

A living will must:

- State how you want your health care decisions to be made in the future.

- Be signed or marked by you and dated.
- Be notarized or witnessed in the same way as described above for a health care power of attorney.

A pre-hospital medical care directive must:

- Be in *exactly* the form required by law. The form must be orange and must list the following treatments which you may refuse:
 1. Chest compression (chest pressure to restart the heart).
 2. Defibrillation (electrically correcting heartbeat).
 3. Assisted ventilation (breathing by machine).
 4. Intubation (supplying air through a tube down the throat).
 5. Advanced life support medications.
- Be signed or marked by you and dated.
- Be signed by a licensed health care provider and a witness.

You should talk to your doctor about pre-hospital directives if you are thinking about signing one.

If you have signed an orange pre-hospital medical care directive, you may also wear a special orange bracelet. It must state your name, your doctor's name, and the words "do not resuscitate". This bracelet will call to the attention of emergency medical personnel that you have completed the form and that you do not want the emergency medical care you have checked on the form.

Q. Who should have copies of your health care directives?

A. It is very important that you give copies to your doctors at once and to any health care facility upon admission. You should give copies to anyone you have named to make health care decisions for you in a health care power of attorney. You may also want to give copies to close family members. Be sure to keep extra Copies for yourself.

SOURCES OF INFORMATION AND FORMS

The following organizations provide health care directive forms and information:

Aging and Adult Administration
State of Arizona
1789 W. Jefferson, Site code 950A
Phoenix AZ 85007 602-542-4446

Arizona Health Decisions
Your Health Care Choices Program
P.O. Box 4401
Prescott, AZ 86302 602-778-4850

Arizona Hospital Association
Communications Department
1501 W. Fountainhead Parkway,
Suite 650
Tempe, AZ 85281 602-968-1083

Arizona Medical Association
810 W. Bethany Home Road
Phoenix, AZ 85013 602-246-8901

Dorothy Garske Center
Your Health Care Choices Program
4250 E. Camelback Road, Suite 185K
Phoenix, AZ 85018 602-952-1464

Your local Area Agency on Aging and Senior Center may also have forms and information.

The following national organizations also provide health care directive forms and information:

American Association of Retired Persons (AARP)
601 "E" Street, N.W.
Washington, DC 20049
202-434-AARP

Choice in Dying
200 Varick Street
New York, NY 10014 212-366-5540

The following organizations provide information and answer questions about health care directives and related legal Matters:

Arizona Senior Citizens Law Project
1818 S. 16th Street
Phoenix AZ 85034 602-252-6710

State Bar of Arizona Arizona Bar Center
363 N. First Avenue
Phoenix, AZ 85003 602-252-4804
Prepared by the Patient Self-Determination Act Committee of the Arizona State Bar and made available by the Arizona Hospital Association and this hospital.

SPECTRA EYE INSTITUTE

**SPECTRA EYE INSTITUTE
ADVANCE DIRECTIVE FOR HEALTH CARE DECISIONS**

Spectra Eye Institute, per Arizona State Law R9-10-1701 through 1710, requires all staff members to recognize the statutory right of a patient who is a competent adult to decide whether to receive or refuse medical treatment. This decision may be in the form of Advance Directives for Health Care Decisions (“Advance Directive”)

If an adult patient is unable to make or communicate health care treatment decisions, Spectra Eye Institute shall make a reasonable effort to locate and follow a health care directive. Spectra Eye Institute shall also make a reasonable effort to consult with a surrogate.

Spectra Eye Institute will not discriminate against a patient based on the existence or non-existence of an Advance Directive.

Any staff member of the facility who is unable or unwilling to comply with this policy shall not impede or prevent any other staff member of the facility from complying with this policy.

An attending physician who is unwilling or unable to follow the Advance Directive of a patient shall, without delay, transfer the patient, or not hinder the transfer of the patient, to another physician who will follow the Advance Directive.

At the time of the facility admission, each adult patient shall be provided with a written summary of Arizona State Law R9-10-1701 through 1710 on Advance Directives, and a written summary of Spectra Eye Institute’s policy on Advance Directives. Each adult patient shall also sign the Advance Directive Acknowledgment.

Advance Directives provided to Spectra Eye Institute by the patient shall be placed in the patient’s medical record.

Any attempt by the patient to revoke an Advance Directive shall be honored.

Patients requesting “Do Not Resuscitate” in their Advance Directive must provide the facility with a written and notarized or witnessed copy. The request must be made known to the health care providers, including the anesthesiologist and surgeon. The patient and surrogate will be assessed for their interpretation of their request, their health status and their understanding of the impending surgical procedure. Based upon this assessment, the anesthesiologist, surgeon and health care providers of Spectra Eye Institute will relay to the patient their anticipated reactions in specific situations.

PATIENT RIGHTS AND RESPONSIBILITIES

Spectra Eye Institute observes and respects a patient's rights and responsibilities without regard to age, color, race, sex, national origin, religion, culture, physical or mental disability, economic status, personal values or belief systems. The patient has the right to exercise his or her rights without subject to discrimination or reprisal; to voice grievance regarding treatment or care that is, or fails to be, furnished; to be fully informed about a treatment or procedure and the expected outcome before it is performed; and to the confidentiality of personal medical information. The patient has the right to personal privacy; to receive care in a safe setting and to be free of all forms of abuse and harassment.

The patient has the right to:

- Be treated with respect, consideration and dignity.
- Expect full recognition of individuality, including personal privacy in treatment and care. In addition, all disclosures and records will be treated confidentially and, except when required by law, patients are given the opportunity to approve or refuse their release.
- Participate in decisions involving their health care, except when participation is contraindicated.
- Be provided with complete information concerning their diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to give such information to the patient, the information shall be provided to a person designated by the patient or to a legally authorized person.
- Be informed of procedures for expressing suggestions, complaints and grievances, including those required by state and federal regulations.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such a refusal. The patient accepts responsibility for their actions should they refuse treatment or not follow instructions of the physician or facility.
- Be informed of any human experimentation or other research/educational projects affecting their care of treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Receive copies of their medical records upon request.
- Be informed of credentials of health care professionals if requested.
- Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the patient transfer.
- Have regular assessment of pain.
- Be informed of their right to change their provider if other qualified providers are available.
- Be provided with information concerning services available at the facility; provisions for after-hours care and emergency care; fee for services; payment policies.
- Expect the facility to comply with Federal Civil Rights laws that assure it will provide interpretation for individuals who are not proficient in English.

The patient is responsible to:

- Provide complete and accurate information to the best of their ability about their health; any medications, including over-the-counter products and dietary supplements; and any drug or other allergies or sensitivities.
- Report whether they clearly understand the planned course of treatment and what is expected of them.
- Follow the treatment plan prescribed by their provider.
- Inform the provider about any living will, medical power of attorney, or other directive that could affect their care.
- Provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider.
- Be respectful of all the health care providers and staff, as well as other patients.
- Be considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Accept financial responsibility for any charges not covered by their insurance.
- Payment for facility copies of the medical records the patient may request.

PATIENT RIGHTS AND RESPONSIBILITIES

If you need a translator / interpreter:

If you will need a translator or interpreter, please let us know and one will be provided for you. If you have someone who can translate or interpret confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

Advance Directives:

You have the right to information on the facility's policy regarding Advance Directives. Advance Directives will not be honored within the center. In the event of a life-threatening event, emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family. If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes. If you request, an official state Advance Directive Form will be provided to you.

Complaints:

If your complaint is not resolved to your satisfaction, you have the right to request a review by the following organizations:

Jan Amator, Administrator
Spectra Eye Institute
9849 West Thunderbird Boulevard
Sun City, AZ 85351
623-583-2020
janspectra@cox.net

Arizona Department of Health
150 N. 18th Ave., 4th Floor
Phoenix, AZ 85007
602-364-2536

1-800-MEDICARE
www.cms.hhs.gov/center/ombudsman

SPECTRA EYE INSTITUTE, LLC

Grievance Procedure

POLICY

Provide our patients and their families with appropriate recourse for problems and concerns.

PROCEDURE

Our patients and their families should be treated with courtesy and respect. Patients or concerned parties are free to discuss problems with any of our staff members. If the patient or concerned party is not comfortable speaking with a staff member, or if he/she receives an unsatisfactory answer, the Director of Nursing should be notified. Should the concern not be resolved at this point, the Medical Director will be contacted.

1. If the grievance pertains to a billing or a monetary matter the Administrator will handle the matter. If the issue cannot be resolved between the Administrator and the patient, the patient's attending surgeon will be asked for guidance. If the attending surgeon and the Administrator cannot resolve the grievance to meet the patient's satisfaction, the Governing Body will address the issue.
2. For all matters other than billing or monetary, a grievance will be handled through the Director of Nursing. The Director of Nursing will be kept apprised of all grievances expressed. If the Director of Nursing cannot resolve the issue to meet the patient's satisfaction, the matter will be brought to the attention of the attending surgeon. If the attending surgeon and the Director of Nursing cannot resolve the issue to meet the patient's satisfaction, the Governing Body will address the issue.
3. All grievances will be handled through the Total Quality Management Committee and reported to the Governing Body on a quarterly basis.
4. For any issue that is addressed by the Governing Body, the Medical Director will inform the patient of the outcome in writing.

All staff will be given this information upon hire and reminded of the procedure at departmental inservices throughout the year.

**SPECTRA EYE INSTITUTE
9849 W. THUNDERBIRD BLVD.
SUN CITY ARIZONA 85351**

To all Patients, Family, and/or Friends:

Please be advised that your surgical experience at Spectra Eye Institute will take approximately 2-4 hours (sometimes more or less depending on the physician and emergency cases).

It is hard to determine the exact amount of time you will be here, however, we want your experience to be the best possible, so please be patient with all of us!

Thank you for your cooperation,

Spectra Eye Institute Management

Spectra Eye Institute, LLC

9849 West Thunderbird Blvd

Sun City, Arizona 85351

(623) 583-2020

Spectra Eye Institute Surgical Facility Fees

You have been referred to our facility by your ophthalmologist. Please follow any instructions that were given to you by your doctor and if you should have any questions before the surgery please contact your doctor's office.

Please be sure to bring your insurance cards with you on the day of surgery as we are not affiliated with the surgeon's offices. Please come prepared to pay your deductible, co-pay and/or co-insurance at the time of surgery. If you are unable to pay your co-pay/co-insurance, or are unsure of what your responsibility is, please contact Spectra Eye Institute prior to surgery.

You may pay by cash, check, money order, debit card, VISA or Mastercard.

Thank you for your cooperation.

Spectra Eye Institute

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NOTICE TO PATIENTS:

Arizona State Law, A.R.S. 32-1401 (ff), requires that an Ambulatory Surgical Center (ASC) notify a patient if the referring physician has a direct interest in the ASC as a separate diagnostic or treatment agency. The ASC must also notify the patient that the service is available elsewhere on a competitive basis. We support this law because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, Dr. _____
has a direct interest in SPECTRA EYE INSTITUTE.

The law requires the acknowledgment of you having read and understood this disclosure by dating and signing this notice in the spaces provided below. We will keep the signed original in your patient file and you will receive a copy.

ACKNOWLEDGMENT

I have read this Notice to Patients and I understand the disclosure that it contains.

Dated this _____ day of _____, 20_____

Patient Signature

Patient Printed Name

I have witnessed the above patient signature and have given a copy of this Notice to the patient.

Employee Signature

Employee Printed Name

**** PLEASE COMPLETE AND BRING WITH YOU THE DAY OF YOUR SURGERY ****

Patient Health and History - Spectra Eye Institute

Name: _____ Date: _____

Age: _____ Weight: _____ Height: _____ Contacts: Right ___ Left ___ None

Dentures: Upper ___ Lower ___ None ___ Hearing Aids: Right ___ Left ___ None ___

Name of the person taking you home: _____ Relationship: _____

Home Phone: _____ Cell Phone _____

Person to notify in case of an emergency: _____ Relationship: _____

Home Phone: _____ Cell Phone _____

****PLEASE REMOVE ALL JEWELRY PRIOR TO ARRIVAL OR GIVE TO FAMILY MEMBER ****

Doctors: Please list all the main doctors involved in your care:

Name	Reason
_____	_____
_____	_____
_____	_____

Allergies: (list)	Type of Reaction	Are you sensitive to any of following?
_____	_____	Iodine: Topical ___ IV ___
_____	_____	Tape: Paper ___ Cloth ___
_____	_____	Latex ___ If so, reaction: _____

(If more space is needed, please attach a separate sheet with list.)

Anesthesia Reactions:

Have you had any complication related to anesthesia? Yes ___ No ___ General ___ Local ___

Describe reaction: _____

Family member with complications related to anesthesia? Yes ___ No ___

MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY IN PAST OR PRESENT

Heart and Vascular	Genital/Urinary	Endocrine
___ Heart Attack(s) Date(s): _____	___ Kidney or Renal	___ Diabetes
___ Angina/Chest Pain	___ Dialysis/Schedule _____	___ Insulin
___ Irregular Heart Beat/Murmur	___ Other _____	___ Thyroid Disease
___ Abnormal Rhythm	Gastro-Intestinal	___ Other _____
___ High Blood Pressure	___ Liver Disease	Musculo-Skeletal System
___ Heart Failure	___ Jaundice	___ Chronic Back/Neck Trouble
___ Pacemaker	___ Hiatal Hernia/Reflux	___ Arthritis
___ Mitral Valve Prolapse	___ Other _____	___ Multiple Sclerosis
___ Other _____	Blood and Coagulation	___ Other _____
Lungs	___ AIDS/HIV	Other
___ Asthma/Wheezing	___ Hepatitis Type: _____	___ Glaucoma ___ RT ___ LT
___ Emphysema	___ Anemia	___ Hearing Loss ___ RT ___ LT
___ Bronchitis	___ Bruising	___ Breast Feeding
___ Bronchiectasis	___ Other: _____	___ Cancer: Type _____
___ Chronic Cough	Nervous System	___ Recent Cough/Cold
___ TB (or family history)	___ Stroke	___ Other _____
___ Shortness of Breath	___ Seizures/Epilepsy	
___ Sleep Apnea	___ Head/Neck Injury	
___ Other _____	___ Other _____	

