HSS West Side ASC

WELCOME PACKET

610 West 58th Street New York, NY 10019 646.495.3300

HSS West Side ASC

WELCOME

HSS West Side ASC

You are in expert hands. Our world-class surgeons and exceptional staff are dedicated to providing you with the very best sports medicine care. This begins with making the right diagnosis and matching that diagnosis with a specialized treatment plan that is unique to you. Our highly specialized protocols have taken years to perfect and have been proven and tested among the most discerning athletes.

You should feel confident that your pathway to recovery could start in no better place. Our modern and convenient ambulatory surgery center is accredited by The Joint Commission and enjoys an excellent reputation among doctors and patients. In fact, our surgeons consistently receive the nation's highest marks for patient satisfaction, and this surgery center is affiliated with HSS which ranks as the No. 1 orthopedic hospital in the country.

This welcome packet will provide all the information you need in advance of your surgery. We appreciate that you have chosen our surgery center, and we are confident that you will achieve the very best outcome.

Sincerely,

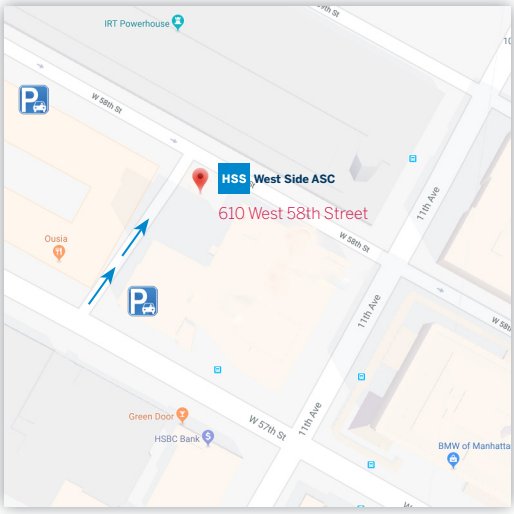
HSS West Side ASC Team

PARKING

The HSS West Side ASC is located at 610 West 58th Street.

Parking is available at a discounted rate at two convenient MTP garage locations identified on the map below. At both locations, an MTP attendant will be available to greet you and issue you a parking ticket. For convenience and efficiency, visitors can text the garage to inform the attendant when they expect to arrive to retrieve their vehicles.

For patient drop off and pick up at the main entrance, please use the through block which is accessible from 57th Street. This is represented with blue arrows on the map.



HSS West Side ASC
610 West 58th Street
New York, NY 10019
646.495.3300

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PATIENT SAFETY WHILE YOU ARE AT THE HSS WEST SIDE ASC

The HSS West Side ASC is always committed to your well-being and safety. Our mission is to provide the highest quality patient care and to improve your mobility and quality of life. One of the ways in which we achieve these goals is by making you an active partner in your care. The purpose of this booklet is to explain ways in which you, your friends and family, and your healthcare team can all play a vital role in providing you with the best care and the best outcomes.

Do share this booklet with your family and friends while you are at the HSS West Side ASC, and remember that we welcome your questions and concerns.

What Should I Know About Patient Safety?

Be an active partner in your care

Together with The Joint Commission, we urge patients to become involved in their care through a program called "Speak Up." "Speak Up" offers simple advice on how you can make your care a positive experience. Research shows that patients who take part in decisions about their healthcare are more likely to have better outcomes.

"Speak Up" means

- Ask questions if you have concerns or do not understand something about your care.
- Let us know if English is not your primary language – we will gladly provide you with interpreter services.
- Say something if you think you are about to receive the wrong medication or if you think the healthcare professional has confused you with another patient.
- Ask members of your healthcare team if they have washed their hands prior to delivering care.
- Share your medical history with your healthcare team.
- Tell us if you have any allergies.
- Ask a trusted family member or friend to be your advocate.

Seeking education about your medical issues and your treatment allows you to be a better partner in your care.

Good communication with your healthcare team benefits everyone. Letting us know your issues and concerns helps us in your care and also keeps you involved as an active partner. Feel free to ask your nurse and other members of the healthcare team to address your concerns.

Know what medications you take and why and when you take them

- Have your list of all the medications you are currently taking, as advised, prior to admission. This includes prescriptions and over-the-counter items like vitamins, herbal supplements, pain relievers, antacids and allergy medications.
- Also have your contact information for your primary care doctor, or the doctor who will be following your care once you leave the HSS West Side ASC including their name, telephone number and fax number.
- Always ask about any medication that is given to you and know why you are taking it.
- Carefully review the medications you are to take once you leave the HSS West Side ASC, and be sure you have the prescriptions and that you understand the discharge and follow-up instructions.
- Please throw away any old medication lists and update your records with any retail pharmacies or providers.
- Should you be discharged on medications such as Coumadin or Lovenox, which are anticoagulants (medications to prevent blood clots), our nurses will provide careful teaching to you and your family or caregivers as to dose, time, diet and follow-up instructions that are all very important for your safety.

Check and double-check identification

- Patient identification: You will be given an identification (ID) band when you arrive at the HSS West Side ASC. This ID band has your name, date of birth (DOB) and medical record number, which helps us to identify you and ensures that we are giving you the proper care and treatment. You will find that your healthcare team will check your ID band and ask for your name and DOB throughout your stay. Please know that this is for your safety. If your ID band falls off or is not easy to read, please ask us for another one.

- Surgical site identification: You will be asked to identify the correct surgical site by pointing to the area where you are due to have surgery, at which time your surgeon will initial the correct surgical site using a special marker. Another safety measure that happens right before your procedure is a "Time Out," in which the healthcare team will confirm patient identity, surgical site, correct procedure and surgery consent form.

Preventing infections

Hand washing is one of the best ways to prevent the spread of infection. HSS West Side ASC staff members are aware of this and will clean their hands with either soap and water or a sanitizing solution (Purell) before and after they provide care for you. If you have not seen someone on your healthcare team wash their hands, we suggest that you ask them to do so.

Avoid falls

- Always press the call bell for help before getting out of bed or while in the bathroom. Your room has many things like foot stools and tray tables that may need to be moved for you to walk safely.

- Always check to see what tubing is connected to you before getting out of bed – for example, IV, pain pump, catheter or airflow foot pumps.

- Use your cane, crutches or walker as directed by your physical therapist prior to the day of surgery.

- Follow your hip or back precautions if you have them.

- Use the handrails in the bathroom as needed.

- Wear your eyeglasses to clearly see your surroundings and to help you with balance.

- Wear non-slip footwear.

- Do not self-medicate while you are in the HSS West Side ASC– your doctor or nurse will give you your medications.

- Be aware, if you have been given a nerve block, it can take a long time to wear off and may have an effect on your ability to stand or walk safely.

- You may feel dizzy and/or drowsy following your procedure. Please allow a member of our medical team to assist you when ambulating.

Remembering these things and making sure to press the call bell when you want to move about will help you to stay safe and have a good recovery.

Your partners in care and safety

Now that you have reviewed this information, you have learned many ways to keep yourself safe throughout your time at the HSS West Side ASC. Of course, you are not alone in this effort. Your healthcare team and the entire staff at the HSS West Side ASC are committed to excellence in all that we do. As such, it is our goal to ensure the highest level of safety for our patients. Remember, "Speak Up," ask questions, share concerns and be mindful of your surroundings. We welcome you as partners in your care and we look forward to getting you up and moving safely to a better quality of life.

WHAT TO BRING ON THE DAY OF SURGERY

The HSS West Side ASC is committed to providing a safe and secure environment during your stay. In order to keep your belongings safe, we kindly request that you do not bring any valuables or unnecessary personal belongings (e.g., suitcases, jewelry, cash, etc.) with you.

Please pack lightly as HSS West Side ASC staff cannot store multiple bags. Belongings that fit into a storage bag issued by the HSS West Side ASC will be secured and stored for you while you are in the operating room. You will be provided with a hospital gown throughout your stay. Any additional personal belongings will be given to your designated visitors or family members for safekeeping. We will not be able to secure any suitcases, luggage or backpacks for you or your visitors. The HSS West Side ASC will not be responsible for any lost or misplaced personal belongings that were not secured by staff.

On the day of surgery, please only bring documents and necessary items as directed by HSS West Side ASC staff.

Pre-Admission Checklist:

- ☐ Bring the legal ID you used when scheduling surgery with your doctor, your health insurance card and prescription cards.
- ☐ Bring medical information as requested by HSS West Side ASC staff and physicians, such as lab reports, advance directives and immunization status information.
- ☐ Bring a list of medications, including how often you take them, indication and dosage (Do not bring the medications with you on the day of surgery unless instructed by staff).
- ☐ Remember your dentures, eyeglasses and essential medical equipment such as braces, crutches, walkers and canes.
- ☐ Wear comfortable clothing and non-slip shoes (athletic footwear).
- ☐ Identify no more than one visitor to accompany you during your surgical day.

Escort Policy:

- All patients must be discharged in the company of a responsible adult known to you (over the age of 18).
- Failure to have a confirmed escort present prior to the procedure will result in cancellation of the procedure.

MYHSS ONLINE PATIENT PORTAL

With the **MyHSS** online patient portal, you are able to:

Complete your Visit Pre-Check:
Submit pre-visit questionnaires, select your preferred pharmacy and more

Manage your appointments:
Request an appointment or view details of your past and upcoming appointments

Request prescription refills

Access your test results

View your health summary:
Review medications, allergies and current health issues

Communicate with your healthcare team

You can also:

- View educational materials
- View statements and pay HSS West Side ASC bills (ASC bills and bills for select providers)
- Request a copy of your medical record
- Complete clinical questionnaires on your health progress

MyHSS is not for medical emergencies.
If urgent care is required, please call 911.

To activate your secure, personal **MyHSS** account, follow these simple steps:

1. Go to: https://myhss.hss.edu/MyHSS/signup.
2. After entering your demographic information, you will be prompted to answer some questions to verify your identity.*
3. When prompted, create your **MyHSS** username. Many patients use their primary, personal email address for this since it is easy to remember.
4. When prompted, create your **MyHSS** password. You can change your password at any time.
5. You'll then be prompted to choose a password hint. This can be used if you forget your password.
6. When prompted, choose your communication preference. You'll be asked to enter a valid email address to receive notifications when new information is available. Once you are signed in to **MyHSS**, you can elect to receive notifications and messages from HSS through a mobile device.
7. Click 'Sign In.' You'll then be able to see portions of your medical record.

*We have partnered with Experian Precise ID® to provide electronic identity verification. If your identity cannot be verified electronically, you will need to confirm your identity in person at your next visit to receive an activation code.

If you need help navigating the portal or if you have any technical issues (i.e., login problems and password resets), call the **MyHSS** Help Desk at 844.269.4509.

ANESTHESIOLOGY

East River Medical Associates, P.C.
535 East 70th Street
New York, NY 10021

Dear Patient:

The anesthesiologists at the HSS West Side ASC will play a vital role in your upcoming surgery, administering anesthesia to ensure your comfort and safety during your surgical procedure and entire HSS West Side ASC stay. After your surgery, your anesthesiologist will care for you in the recovery room and, in addition, your surgeon may consult an anesthesiologist from our acute pain team to treat your post-surgical pain.

Similar to your surgeon's charges, the anesthesiologist's professional fees are not included in your HSS West Side ASC bill. While all of our anesthesiologists participate with Aetna, Affinity, Empire Blue Cross Blue Shield, Cigna, ConnectiCare, Emblem SelectCare, HIP Health Plan of New York, Oxford, United, Medicare, Medicaid, Workers Compensation and No-Fault, we recommend that you contact our billing company, Billing Services, Inc. (BSI), or your insurance carrier to confirm coverage under your particular plan.

Even if we participate with your carrier, depending on the specifics of your plan, you may be responsible for payment of a co-pay, deductible or co-insurance. If we do not participate with your insurance carrier, please contact BSI or your carrier to confirm the extent of coverage under your plan.

Please be reminded that if there is an outstanding balance after insurance has processed your claim, whether deductible, co-pay, co-insurance or for any other reason, you will be responsible for payment of this balance.

Regardless of your insurance carrier or our participation status with that carrier, after your surgery you will receive a bill for anesthesia services. BSI will also file this claim directly with your carrier. In some cases you may be asked to speak with your carrier to ensure that we are paid appropriately for our services. BSI will enable and assist you in this process. Finally, in the event that your insurance carrier sends you the check for anesthesia services, you are responsible for forwarding that payment to us.

If you have other questions about your anesthesia bill, please contact BSI toll-free at 888.877.3850 (Monday-Friday from 9am to 5pm).

With best wishes for your upcoming surgery,

East River Medical Associates, P.C.

PAYING FOR YOUR CARE AT HSS WEST SIDE ASC

HSS West Side ASC is a participating provider in a growing number of health plan networks. You can find a list of the insurance plans in which we participate at www.hss.edu/asc-insurance. It is important to check whether we participate in the specific plan by which you are covered.

Certain licensed facilities are required by law to make available information about the fees you may be billed that may not be covered by your healthcare plan. To obtain an estimate and more specific information regarding charges and insurance coverage, you may contact the Hospital for Special Surgery Insurance Advisory Service. They can serve as a liaison service between you, your insurance carrier and the HSS West Side ASC to provide information regarding your potential out of pocket responsibilities for copayments, deductibles and co-insurance amounts. Hospital for Special Surgery Insurance Advisory Service can be reached at 212.774.2607 or through our online form located at www.hss.edu/insurance-form.

The physician services you receive in the HSS West Side ASC are not included in the HSS West Side ASC charges. In addition to the bill for the HSS West Side ASC facility fee, you will receive separate bills for the following services:

- Your Surgeon
- Anesthesia Provider – East River Medical Associates 212.606.1206
- Pathology – If tissues or specimens were removed during surgery you will receive a technical bill from Hospital for Special Surgery and a professional bill from HSS Pathology 212.774.2607

The above providers make their own decisions regarding participation in insurance plans and may or may not participate in the same health plans as the HSS West Side ASC. Contact and plan participation information for these physicians and physician practice groups can be found at www.hss.edu/physicians.

If you are concerned that you may not be able to pay in full for your care at the HSS West Side ASC, you may be eligible for financial assistance. We provide financial aid to patients based on income, assets and needs. Information about financial assistance is available at www.hss.edu/asc-financial-assistance or you may contact our Financial Assistance Office at 212.606.1505.

PROVIDING FEEDBACK

HOW THE HSS WEST SIDE ASC RESPONDS TO PATIENT COMPLAINTS

If you have any issue or concern regarding your care, or have a question regarding the HSS West Side ASC policies and procedures, please contact the Site Administrator between the hours of 9am-5pm Monday through Friday at 212.774.7026 and you will be contacted within 24 hours of your call.

If you wish to file a grievance with the HSS West Side ASC, you can report your grievance verbally or in writing. You will receive an acknowledgment that we are in receipt of your grievance within seven business days. You will be informed about the resolution of the grievance within 45 business days, or under unusual circumstances, you will be notified if additional time is needed for the investigation.

In addition, you may report a complaint to:

1. Any HSS West Side ASC staff member or manager, director, supervisor or nurse in charge.

2. Executive Office of HSS West Side ASC by phone at 212.774.7026 or letter sent to HSS West Side ASC, 610 West 58th Street, New York, NY 10019.

3. New York State Department of Health by phone at 800.804.5447 or letter sent to NYS Department of Health, Centralized Hospital Intake Program, Mailstop: CA/DCS, Empire State Plaza, Albany, NY 12237.

4. The Joint Commission by phone at 800.994.6610 or letter sent to Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, or email to complaint@jointcommission.org.

5. Medicare Patients Only: Livanta by phone at 866.815.5440 or letter sent to BFCC-QIO Program, 9090 Junction Drive, Suite 10, Annapolis Junction, MD 20701.

Additional information can be found in the Patient Rights section of this packet.

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient in an ambulatory surgery center in New York State, you have the right, consistent with law, to:

(1) Receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, disability, sexual orientation, gender identity or expression, national origin or sponsor.

(2) Be treated with consideration, respect and dignity including privacy in treatment.

(3) Be informed of the services available at the center.

(4) Be informed of the provisions of off-hour emergency coverage.

(5) Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced care costs.

(6) Receive an itemized copy of his or her account statement, upon request.

(7) Obtain from his or her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his or her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.

(8) Receive from his or her physician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision.

(9) Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his or her action.

(10) Refuse to participate in experimental research.

(11) Voice grievances and recommend changes in policies and services to the center's staff, the operator and the New York State Department of Health without fear of reprisal.

(12) Express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his or her designee that if the patient is not satisfied by the center response, the patient may complain to the New York State Department of Health's Office of Health Systems Management.

(13) Privacy and confidentiality of all information and records pertaining to the patient's treatment.

(14) Approve or refuse the release or disclosure of the contents of his or her medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract.

(15) Access his or her medical record pursuant to the provision of section 18 of the Public Health Law, and Subpart 50-3 of Title 10 of the Compilation of Codes, Rules and Regulations of the State of New York.

(16) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.

(17) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card available from the center.

In accordance with NY State Public Health Law 2980-2994, we must inform you of the center policy on Advance Directives. Advance Directives include but are not limited to a health care proxy, consent to do not resuscitate (DNR), order recorded in your medical record (MOLST) or living will. Hospital for Specialty Surgery West Side Ambulatory Surgery Center, LLC ("HSS ASC") is an Ambulatory Surgery Center for the purpose of performing elective procedures on individuals who do not have complex medical conditions and are expected to tolerate the procedures well without complications. It is the ASC's policy that if a patient experiences a complication the center staff will make every effort to resuscitate the patient and transfer that patient to a hospital in the event of the need for follow up care.

If a patient brings in his/her Advance Directive a copy will be placed in the patient's medical record and transferred with the patient should a hospital transfer be necessary. The center will provide you with a health care proxy form upon request.

ADVANCE DIRECTIVES POLICY

1. HSS ASC supports every patient's right to participate in their own health care decisions and to make advance directives or execute powers of attorney that authorize others to make decisions on their behalf when they are unable to make or communicate such decisions..

2. Advance directives are legal documents and instructions that govern how your health care decisions are made and notify your health care providers and others about your wishes in the event you become incapacitated and unable to make decisions on your own. New York law recognizes the following types of advanced directives:

    a. **Health Care Proxies: A health care proxy allows you to appoint a person that you trust, such as a family member or close friend, to make health care decisions on your behalf if you lose the ability to make such decisions yourself. By appointing a health care proxy you can ensure that, even in the event of unanticipated changes in your medical condition, the treatment you receive will be consistent with your wishes, values and beliefs. Your health care providers must follow the decisions made by your proxy as if they were your own.**

    b. **Living Wills:** A living will allows you to leave written instructions about your health care wishes. It can be used in conjunction with a health care proxy to give your proxy and health care providers additional guidance about your wishes.

    c. **Do Not Resuscitate Order ("DNR"):** A DNR allows you to express that, in the event of a medical emergency, you do not wish to receive cardiopulmonary resuscitation ("CPR") to restart your heartbeat or breathing. A DNR only applies to CPR decisions and does not allow you to make written instructions about other aspects of care.

    d. Please speak with your physician about your treatment wishes and any questions you may have about advance directives before your procedure. Please provide copies of any advance directives you may have to your physician. Advance directive forms are available at the HSS ASC as well as on the New York State Department of Health website at www.health.ny.gov/professionals/patients/health_care_proxy/.

PATIENT CONSENT TO RESUSCITATIVE MEASURES

As a patient, you have the right to make advance directives and change them at any time. The Hospital for Special Surgery West Side Ambulatory Surgery Center, LLC ("HSS ASC") recognizes the importance of advance directives and upholds your rights to make your own health care decisions. However, unlike in a hospital setting, the scope of services provided at HSS ASC is limited to elective outpatient surgeries for patients who receive medical clearance to undergo such procedures.

Therefore, it is the policy of HSS ASC that, regardless of the contents of any advance directive or instructions from a health care proxy, if an adverse event or medical emergency occurs during your treatment at HSS ASC, our professional personnel will initiate resuscitation and other stabilizing measures and will transfer you to an appropriate hospital for further evaluation. At the hospital, further treatment, or withdrawal of treatment, will be ordered in accordance with your wishes, advance directives or instructions from your health care proxy or attorney in fact.

By signing below, you (or your legal representative) acknowledge and agree that:

(i) you have read and understand this Advance Directives Policy and Patient Consent to Resuscitative Measures;

(ii) you had the opportunity to discuss the Advance Directive Policy, the Patient Consent to Resuscitative Measures, your treatment wishes and any questions you may have about advance directives with your physician before undergoing a procedure at HSS ASC;

(iii) you have provided your physician with a copy of any advance directives you may already have in place prior to your scheduled procedure; and

(iv) In accordance with this Advance Directive Policy and Patient Consent to Resuscitative Measures, you agree to waive any DNR and other aspects of advance directives you may have in place regarding CPR and other life-sustaining measures while you receive treatment at HSS ASC.

This waiver shall only apply during your treatment at HSS ASC and will not revoke or invalidate any DNR or other advance directive you may have in other settings. However, if for any reason you do not agree to this Patient Consent to Resuscitative Measures, HSS ASC will cancel your procedure and help you identify a hospital or another facility where the procedure may be performed.

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

If signed by a legal representative of the patient:

NAME OF REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: _____

SAMPLE CONSENT FOR OPERATION AND/OR PROCEDURE

Hospital for Special Surgery
West Side Ambulatory Surgery Center, LLC

CONSENT FOR OPERATION AND/OR PROCEDURE

Patient Name: _____ Date of Birth: _____

Medical Record Number: _____ Date: _____

I hereby give consent to Doctor(s): _____
and Hospital for Special Surgery West Side Ambulatory Surgery Center, LLC ("ASC") and its staff that perform these surgical procedures and other related processes and therapeutic services, as they may consider necessary, to include the following operation and/or procedure using the implant/implant system cited (if any):

_____
_____
_____
_____

Implant System (if applicable)**:**_____
(Description of the operation and/or procedure, including the name of the implant/implant system to be used)

PATIENT VERIFICATION OF SURGICAL SIDE

□ **Left** □ **Right** □ **Bilateral**

□ **Anterior** □ **Posterior**

Patient's Initials: _____

The surgeon(s) and/or physician(s) named above have explained and have discussed with me the nature, intended purpose, anticipated benefits, material risks, and possible complications of this operation/procedure, the alternative therapies if such operation/procedure is not performed, and the probable consequences if this operation/procedure or alternative therapies are not performed.

I give this consent with the full knowledge and understanding that medicine is not an exact science, that there is the possibility that the operation/procedure may not have the benefits or results intended, and that there are always risks and dangers to life and health generally associated with medical procedures and treatments that can cause adverse consequences not ordinarily anticipated in advance.

I understand that during the operation/procedure, unforeseen conditions may be revealed or encountered and that surgical or other procedures in addition to or different from those described above may be necessary or advisable to treat address those conditions. I also understand that depending on the circumstances, the surgeon/physician named above may choose to use an implant/implant system different from that specified above, or none at all. I give my consent to the surgeon(s)/physician(s) cited above or the people they designate to perform these additional surgical or other procedures on me/the patient, and use these alternative

implants/implant systems, as they may deem necessary or advisable.

I understand that some important surgical tasks can be performed by practitioners other than the surgeon(s)/physician(s) cited above, and I give my consent for them to do so. The specific tasks will be determined based on the practitioner's skill set, the scope of practice under the laws of New York, and the privileges granted by ASC, and will be performed under the supervision of the surgeon(s)/physician(s) named above. Qualified medical practitioners who are not physicians (physician assistants and specialist assistants) may open and close, dissect tissue, remove tissue, harvest grafts, and place invasive lines.

I grant permission to ASC to use any of the tissues, organs and hardware (including implants and instruments) that are removed from me/the patient during the operation/procedure for medical, scientific and/or educational purposes. I give my consent for ASC to dispose of any of these tissues, organs and hardware in compliance with customary practices.

I give my consent for photographing, videotaping, televising or other observation of the operation as ASC or the aforementioned surgeon/physician may deem useful or appropriate for scientific and/or educational purposes, with the understanding that my/the patient's identity will remain confidential. I give my consent to the presence during the operation/procedure of a visitor or visitors, who may include a visiting doctor and/or a vendor representative whose presence has been requested by the aforementioned surgeon(s)/physician(s). I understand that the visitor(s) will be under the constant supervision and direction of the surgeon(s)/physician(s) cited above and other ASC staff and will be subject to all the relevant policies and procedures of ASC.

I confirm that I have read and understood this document in its entirety, I was given the opportunity to ask questions regarding the operation/procedure and my questions were answered satisfactorily, and that I am eligible to give this consent.

Signature of the Patient or Legal Representative: _____

Print Name: _____ **Date:** _____ **Time:** _____

If Legal Representative, relationship to the patient:_____

Witness's Certification: I certify that I witnessed the signing of this Consent for Operation and/or Procedure by the person whose signature appears above.

Witness Signature: _____ **Print Name:** _____

Date: _____ Time: _____

Certification of the Surgeon(s)/Physician(s):
I/we certify that I/we have explained and discussed with the person whose signature appears above, the nature, intended purpose, anticipated benefits, material risks, and possible complications of the operation/procedure specified above, the alternative therapies, and the probable consequences if the aforementioned operation/procedure or alternative therapies are not performed.

Surgeon/Physician Signature: _____ Print Name: _____

Date: _____

SAMPLE GENERAL CONSENT/FINANCIAL AGREEMENT

Hospital for Special Surgery
West Side Ambulatory Surgery Center, LLC

GENERAL CONSENT/ PERMISSION FOR TREATMENT AND FINANCIAL AGREEMENT

I authorize and consent to performance upon _____
(***Insert "me" or Name of Patient***)
by Hospital for Special Surgery West Side Ambulatory Surgery Center, LLC ("ASC") and its staff of such physical examinations, diagnostic imaging procedures (such as x-rays, CT scans, and/or magnetic resonance imaging (MRI)), laboratory tests, and other non-invasive diagnostic and therapeutic procedures and/or treatments, as my/the patient's physician or others on ASC's medical staff consider to be necessary or appropriate for the purpose of diagnostic and/or treatment of my/the patient's condition.

I understand that for each procedure/treatment the following will be explained to and discussed with me/the patient: the nature, intended purpose, anticipated benefits, material risks, and possible complications of such procedure/treatment; the alternative procedures/treatments if such procedure/treatment is not performed; and the probable consequences if such procedure/treatment or alternative procedures/treatments are not performed.

I give this consent with full knowledge and understanding that medicine is not an exact science, that there is the possibility that the procedure/treatment may not have the benefits or results intended, and that there are always risks and dangers to life and health associated generally with medical procedures and treatments that can cause adverse consequences not ordinarily anticipated in advance.

I consent to the diagnostic study by ASC of any blood, urine or other bodily fluids, stool specimens, or tissues that are obtained in the performance of such procedures/treatments, and to the disposal of such fluids/ specimens/tissues by ASC in accordance with its customary practice. I further grant permission for ASC to use such fluids/specimens/tissues for medical, scientific and/or educational purposes.

I consent to the photographing, videotaping, televising, or other observation of the procedures/treatments at ASC or its surgeon(s)/physician(s) may deem useful or appropriate for scientific and/or educational purposes, with the understanding that my/patient's identity will remain confidential.

I consent to the presence during the procedures/treatments of a visitor or visitors, which may include any visiting physician(s) and/or vendor representative(s) whose presence has been requested by the above named surgeon(s)/ physician(s). I understand that the visitor(s) will at all times be under the supervision and direction of the above named surgeon(s)/physician(s) and other ASC personnel, and subject to all relevant ASC policies and procedures.

I understand that information about me/the patient will be disclosed as required by applicable law, including reporting mandated by the federal, state and local governments to oversight agencies such as Centers for Disease Control and Prevention, the New York State Department of Health, and the New York City Department of Health and Mental Hygiene. Examples of such mandated reporting include reporting of suspected or confirmed communicable diseases, child abuse, firearm wounds, and certain knife wounds and burns.

I understand that ASC does not provide all of the medical services that I/the patient could ever possibly require, and that in the event I/the patient need treatment not provided by ASC during the time I receive care at ASC, it may become necessary to transfer me to a hospital that provides the medical services required by me/the patient (including, New York-Presbyterian Hospital). I hereby consent to the transfer to such hospital of me for such treatment when ASC determines that transfer is medically necessary or advisable.

I understand that ASC will electronically transmit prescriptions to my pharmacy (ePrescribing) as required by New York law. I also understand that in connection with ePrescribing, ASC and members of its Medical Staff will obtain medication history (information about the medications I/the patient are currently taking or have taken within the past year) for purposes of coordinating my/the patient's treatment. I hereby consent to ePrescribing by ASC and members of its Medical Staff, including obtaining my medication history and making it part of the ASC medical record.

FINANCIAL AGREEMENT

Assignment of Benefits
I assign, transfer and set over to ASC and members of its Medical Staff sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, and others who are financially liable for hospitalization and medical care of me/the above-named patient by ASC and its Medical Staff.

If I am entitled to Medicare benefits, I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductibles on all services, and any co-payment or co-insurance applicable to the services provided by the ASC. I also understand that when Medicare is deemed that secondary insurance responsible for payment of my medical care, I will be financially classified under the ASC's policies and will follow payment terms under said policies.

Authorization for Release of Information
I authorize and direct ASC and its Medical Staff to release to government agencies, insurance carriers, and others who are financially liable for the medical care of me/the above-named patient, all information needed to substantiate and obtain payment for such hospitalization and medical care, and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Guarantee of ASC Charges
I agree to be responsible for payment in full of the charges for all medical care rendered to me/the above-named patient for this period of care. I understand that even if I have/the patient has domestic or international health insurance coverage accepted by ASC, I will be responsible for payment in full of unpaid balances after insurance company payment to ASC, to the full extent permitted under federal, state and local laws. I understand that my responsibility also includes payment for charges not ordinarily covered by health insurance.

Personal Property; Release of Liability
I understand that (i) I am solely responsible for any and all costs of items of personal property that I choose to keep with me and/or use while at the ASC; (ii) the ASC strongly recommends that I leave at home all personal property of value to me, including but not limited to money, checks, jewelry, credit cards, and clothing; and (iii) any items of personal property that I leave behind after I leave the ASC facility will not be the ASC's responsibility. I hereby release ASC and its Medical Staff members, employees and agents from any and all liability and claims arising from my keeping personal property with me while I am at the ASC.

I confirm that I have read and fully understand this General Consent/Permission for Treatment & Financial Agreement, that I have been given the opportunity to ask questions and have had my questions answered satisfactorily, and that I am eligible to give this consent and agreement. I further confirm that I understand that I have the right to revoke this consent, or any part of it, at any time during my/the patient's treatment by ASC to the extent it has not already been otherwise relied upon by the ASC.

Signature of Patient or Legal Representative: _____

Print Name: _____

Date: _____ **Time:** _____

If Legal Representative, relationship to patient: _____

Witness Certification: I certify that I have witnessed the person whose signature appears above signing this General Consent/Permission for Treatment & Financial Agreement.

Signature of Witness: _____ **Print Name:** _____

Date: _____ **Time:** _____

East River Medical Associates, P.C.
535 East 70th Street
New York, NY 10021

Dear Patient:

The anesthesiologists at the HSS West Side ASC will play a vital role in your upcoming surgery, administering anesthesia to ensure your comfort and safety during your surgical procedure and entire HSS West Side ASC stay. After your surgery, your anesthesiologist will care for you in the recovery room and, in addition, your surgeon may consult an anesthesiologist from our acute pain team to treat your post-surgical pain.

Similar to your surgeon's charges, the anesthesiologist's professional fees are not included in your HSS West Side ASC bill. While all of our anesthesiologists participate with Aetna, Affinity, Empire Blue Cross Blue Shield, Cigna, ConnectiCare, Emblem SelectCare, HIP Health Plan of New York, Oxford, United, Medicare, Medicaid, Workers Compensation and No-Fault, we recommend that you contact our billing company, Billing Services, Inc. (BSI), or your insurance carrier to confirm coverage under your particular plan.

Even if we participate with your carrier, depending on the specifics of your plan, you may be responsible for payment of a co-pay, deductible or co-insurance. If we do not participate with your insurance carrier, please contact BSI or your carrier to confirm the extent of coverage under your plan.

Please be reminded that if there is an outstanding balance after insurance has processed your claim, whether deductible, co-pay, co-insurance or for any other reason, you will be responsible for payment of this balance.

Regardless of your insurance carrier or our participation status with that carrier, after your surgery you will receive a bill for anesthesia services. BSI will also file this claim directly with your carrier. In some cases you may be asked to speak with your carrier to ensure that we are paid appropriately for our services. BSI will enable and assist you in this process. Finally, in the event that your insurance carrier sends you the check for anesthesia services, you are responsible for forwarding that payment to us.

If you have other questions about your anesthesia bill, please contact BSI toll-free at 888.877.3850 (Monday-Friday from 9am to 5pm).

With best wishes for your upcoming surgery,

East River Medical Associates, P.C.

SAMPLE CONSENT FOR ANESTHESIA AND ANALGESIA

Hospital for Special Surgery
West Side Ambulatory Surgery Center, LLC

CONSENT FOR ANESTHESIA AND ANALGESIA

I hereby give consent to Doctor(s) _____
and Hospital for Special Surgery West Side Ambulatory Surgery Center, LLC ("ASC") and its staff to administer to _____ ***(Insert "me" or Patient's name)*** the following type of anesthesia:

_____

_____

Patient Verification of Procedure/Surgical Side

□ **Left** □ **Right** □**Bilateral (Both)**

Patient's Initials: _____

I consent to my Doctor, ASC and its staff to use such anesthetic agents and medications as may be deemed necessary in the course of my/the patient's operation/procedure, and to use such anesthetic procedures and medications as may be required for analgesia (pain relief) after my/the patient's surgical procedure.

The nature, intended purpose, benefits, significant foreseeable risks, complications and consequences of the anesthetic agents and/or medications planned or likely to be administered, and the alternatives if such anesthetic agents and/or medications are not administered, have been explained to and discussed with me by the physician(s) named above.

I give this consent with full knowledge and understanding that medicine is not an exact science, that there is the possibility that the anesthesia may not have the benefits or results intended, and that there are always risks and dangers to life and health associated generally with anesthesia which can cause adverse consequences not ordinarily anticipated in advance.

I understand that during anesthesia it is likely that I/the patient will receive intravenous fluids, and that it also may be necessary to insert catheters (small tubes) or other devices to monitor my/the patient's bodily functions. It is possible that an apparatus may be used to assist my/the patient's breathing.

I understand that unanticipated conditions may arise, in which case alternate anesthetic agents or other medications may need to be used. I give consent to the use of such other anesthetic agents or other medications as the physician(s) named above or his/her/their associates or assistants may deem necessary.

I understand that due to unforeseen scheduling or other reasons, the attending anesthesiologist named above may not be available to treat me/the patient. I therefore give permission to the anesthesiologist in charge to choose another attending anesthesiologist to provide anesthesia and analgesia to me/the patient.

I understand that some important anesthesia and analgesia tasks may be performed by practitioners other than the physician(s) named above, and I consent to their doing so. The specific tasks will be determined based on the practitioner's skill set, scope of practice under New York law, and privileges granted by ASC, and will be performed under the supervision of the physician(s) named above.

Post-graduate physicians (residents and fellows) and qualified medical practitioners who are not physicians (certified registered nurse anesthetists, or CRNAs) may participate in administering anesthesia and analgesia.

I confirm that I have completely reported to the physician(s) named above my/the patient's medical history, including the names of any drug or medication which I/the patient am currently using or have recently used, any allergies which I/the patient now have (or been thought to have in the past) to any drug or medication, and any dental-related conditions.

I understand that there are risks to me associated with the use of anesthetic agents and medications, including bruising, infection, hemorrhage, drug reactions, organ reaction, seizures, blood clots, loss of sensation, loss of limb function, paralysis, blindness, brain damage, and death. I further understand that there is a possibility of damage to my teeth during anesthesia, particularly if they are weak, decayed, artificial, or baby teeth. And, depending on the type of anesthetic agent, I understand that I may experience some discomfort, such as sore throat, hoarseness, headache, or residual loss of sensation, when the anesthetic wears off. I acknowledge that no guarantees or assurances have been made to me concerning the expected result of any anesthetic agent or medication.

Patient of Legal Representative Consent: I confirm that I have read and fully understand this document, that I have been given the opportunity to ask questions about anesthesia and analgesia and all my questions have been answered satisfactorily, and that I am eligible to give this consent.

Signature of Patient or Legal Representative: _____

Print Name: _____

Date: _____ **Time:** _____

If Legal Representative, relationship to patient: _____

Witness Certification: I certify that I have witnessed the person whose signature appears above signing this Consent for Anesthesia Analgesia.

Signature of Witness: _____

Print Name: _____

Date: _____ **Time:** _____

Physician Certification: I certify that I have explained to and discussed with the person whose signature appears above the nature, intended purpose, benefits, significant foreseeable risks, complications and consequences of the anesthetic agents and/or medications planned or likely to be administered, and the alternatives if such anesthetic agents and/or medications are not administered. I further certify that all parties signed this Consent for Anesthesia and Analgesia on the date and at the time set forth below.

Physician Signature: _____

Print Name: _____

Date: _____ **Time:** _____

STATEMENT OF PATIENT'S RESPONSIBILITIES

The Statement of Patient's Responsibilities, designed as a companion to the Patient's Bill of Rights, encourages patients to participate in their own healthcare and treatment.

The HSS West Side ASC believes that a mutual understanding of the Patient's Bill of Rights and Responsibilities will result in more effective delivery of healthcare services.

The HSS West Side ASC requests that patients be responsible for:

1. Bringing a responsible adult to your appointment to accompany you following your procedure.
2. Being considerate of other patients and personnel and for assisting in the control of noise and other distractions.
3. Respecting the property of others and the facility and abiding by no smoking rules.
4. Understanding your health problems and treatment to your own satisfaction and asking questions if you do not understand.
5. Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.
6. Providing accurate and complete information about your past illnesses, hospitalizations, medications and other matters relating to your health, and answering any questions concerning these matters.
7. Observing prescribed rules of the facility during your treatment and, if instructions are not followed, forfeiting the right to care at the facility and being responsible for the outcome.
8. Cooperating with your physician and other healthcare professionals in carrying out your healthcare plan during your stay and after your discharge.
9. Fulfilling your financial obligations to the facility, including providing information related to insurance and other sources of payment.
10. Providing payment to facility for copies of the medical record requests.
11. Identifying and communicating any patient safety concerns during the course of your care.

We also ask that you be considerate of your fellow patients, respecting their need for privacy and a quiet environment, as we expect them to do for you as well.

For emergencies after discharge from the HSS West Side ASC, call 911.

For after-hours questions about symptom management call the attending surgeon and a physician will get back to you. THIS INFORMATION IS ON YOUR DISCHARGE INSTRUCTIONS.

NOTICE OF PRIVACY PRACTICES

Effective Date: July 12, 2017

THIS NOTICE OF PRIVACY PRACTICES ("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.

Respect for our patients' privacy is highly valued at HSS West Side ASC. Not only is it what our patients expect, it is the right way to conduct healthcare. As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice which describes the health information privacy practices of HSS West Side ASC, its medical staff and affiliated health care providers when, providing health care services for HSS West Side ASC. Our Notice will be prominently posted. You will also be able to obtain your own copy of our Notice by accessing our website at www.hss.edu/asc, calling HSS West Side ASC at 212.774.7026, or asking for one at the time of your next visit.

If you have any questions about this Notice or would like further information, please contact the ASC's Privacy Officer at 212.774.7026.

WHO WILL FOLLOW THE PRACTICES IN THIS NOTICE?

HSS West Side ASC provides healthcare to patients together with physicians and other health care professionals and organizations. The privacy practices described in this Notice will be followed by:

- Any health care professional who provides direct services to treat you at HSS West Side ASC; and
- All employees, medical staff, trainees, students, and volunteers at HSS West Side ASC who provide direct HSS West Side ASC services.

The privacy practices described in this Notice do not apply when care is being provided to you in the private offices of HSS West Side ASC's medical staff or other health care professionals. For example, if a doctor provides surgical services at HSS West Side ASC, the privacy practices described in this Notice will apply. If you are seen by the same doctor for a follow-up appointment at his or her private office, the privacy practices in this Notice will not apply. The doctor should provide you with a separate Notice explaining the privacy practices that will apply to his or her private office. In addition, the privacy practices described in this Notice do not apply to members of HSS West Side ASC's medical staff or other members of our workforce when they treat you at other hospitals or facilities.

PERMISSIONS DESCRIBED IN THIS NOTICE

This Notice will explain the different types of permission we will obtain from you before we use or disclose your health information for certain purposes. The two types of permissions referred to in this Notice are:

- An "opportunity to object" which we will provide to you before we may use or disclose your health information for certain purposes. In these situations, you will have an opportunity to object to the use or disclosure of your health information in person, over the phone, or in writing.
- A "written authorization" in which we will provide you with detailed information about who may receive your health information for certain specific purposes. We will only be permitted to use and disclose your health information described on the written authorization in the ways that are explained on the written authorization form you have signed. A written authorization will have an expiration date or event.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information indicating that you are a patient at HSS West Side ASC or receiving treatment or other health-related services from HSS West Side ASC;
- information about your health condition (such as a disease you may have);
- information about healthcare products or services you have received or may receive in the future (such as an operation); or
- information about your healthcare benefits under an insurance plan (such as whether a prescription is covered);

when combined with:

- demographic information (such as your name, address, or insurance status);
- unique numbers that may identify you (such as your Social Security number, your phone number, or your driver's license number); or
- other types of information that may identify who you are.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Requirement for Written Authorization. We will generally obtain your written authorization before using your health information or sharing it with others outside HSS West Side ASC.

Exceptions to Written Authorization Requirement. There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

1. Treatment, Payment, and Health Care Operations

We may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our health care operations. In some cases, we may also disclose your health information for payment activities and certain health care operations of another health care provider or payor.

Treatment. We may share your health information with doctors, nurses and other health care providers at HSS West Side ASC who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A doctor at HSS West Side ASC may share your health information with another doctor inside HSS West Side ASC, or with a doctor at another hospital, to determine how to diagnose or treat you. Your doctor may also share your health information with another doctor to whom you have been referred for further health care. Payment. We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you, or to determine whether it will cover your treatment. We might also need to inform your health insurance company about your health condition in order to obtain pre-approval for your treatment. Finally, we may share your information with other health care providers and payors for their payment activities.

Health Care Operations. We may use your health information or share it with others in order to conduct our health care operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide. Finally, we may share your health information with other health care providers and payors for certain of their health care operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your health information.

Appointment Reminders, Treatment Alternatives, or Distribution of Health-Related Benefits and Services. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment or services at our facility. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you. However, to the extent a third party provides financial remuneration to us so that we make these treatment-related or health care operations-related communications to you, we will secure your authorization in advance as we would with any other marketing communication (as described later in this Notice).

Business Associates. We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our health care operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company. Another example is that we may share your health information with an accounting firm or law firm that provides professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract that requires our business associate to protect the privacy of your health information.

2. Patient Directory and Family and Friends

We may use your health information in, and disclose it from, our Patient Directory, or share it with family and friends involved in your care, without your written authorization. You will have an opportunity to object to these uses and disclosures of your health information unless there is insufficient time because of a medical emergency (in which case we will discuss your preferences with you as soon as the emergency is over). We will follow your wishes unless we are required by law to do otherwise. Patient Directory. If you do not object, we will include your name, your location in our facility, your general condition (e.g., fair, stable, critical, etc.), and your religious affiliation in our Patient Directory while you are a patient in HSS West Side ASC. This directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if he or she doesn't ask for you by name. Family and Friends Involved In Your Care. If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care. We may also notify a family

member, personal representative, or another person responsible for your care about your location and general condition here at HSS West Side ASC. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons.

3. Emergencies or Public Need

We may use your health information, and share it with others, in order to treat you in an emergency or to meet important public needs. We will not be required to obtain your written authorization or to provide you with an opportunity to object before we use or disclose your health information for these reasons. We will, however, obtain your written authorization for, or provide you with an opportunity to object to, the use and disclosure of your health information in these situations when state law specifically requires that we do so.

Emergencies. We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you. As Required By Law. We may use or disclose your health information if we are required by law to do so. We will notify you of these uses and disclosures if notice is required by law.

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury, or disability. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if the law requires or permits us to do so. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work-related injury or disease that your employer must know about in order to comply with employment laws.

Victims of Abuse, Neglect, or Domestic Violence. We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect, or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of such abuse, neglect, or domestic violence. We will make efforts to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Product Monitoring, Repair, and Recall. We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits and Disputes. We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

Law Enforcement. We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws that we are required to follow;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your agreement because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect that your death resulted from criminal conduct;
- If necessary to report a crime that occurred on our property; or
- If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

To Avert a Serious and Imminent Threat to Health or Safety. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

National Security and Intelligence Activities or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Military and Veterans. If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates and Correctional Institutions. If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security, and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation. We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners, and Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release your health information to funeral directors as necessary to carry out their duties.

Organ and Tissue Donation. In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes, or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

Research. In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information without your written authorization if we obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

4. Completely De-identified or Partially De-identified Information

We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you for research, public health, or health care operations purposes if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, Social Security number, phone number, fax number, electronic mail address, website address, or license number).

5. Incidental Disclosures

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION REQUIRING AUTHORIZATION

As stated above, HSS West Side ASC cannot and will not use or disclose your health information without your written authorization for any reason, except those described in this Notice. For example, we require your written authorization for most uses or discloses of your health information for certain marketing purposes, for the sale of health information, or with respect to psychotherapy notes (where appropriate). In addition, you may initiate the transfer of your records to another person or organization by completing an authorization form. If you provide us with written authorization, you may revoke, or cancel, that written authorization at any time, except to the extent that we have already relied upon it. If you revoke the authorization, we will no longer use or disclose your health information for the reasons covered by your written authorization. Your revocation will not affect any uses or disclosures we have already made prior to the date we receive notice of the revocation. To revoke a written authorization, please write to HSS West Side ASC, Attn. Privacy Officer, 610 West 58th Street, New York, NY, 10065.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters.

1. Right To Inspect And Copy Records

You have the right to inspect and obtain a copy, including an electronic copy, from us in a timely manner of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records.

How to Make Your Request: To inspect or obtain a copy of your health information, please submit your request in writing to HSS West Side ASC, Attn. Privacy Officer, 610 West 58th Street, New York, NY, 10065. A request to inspect or obtain a copy of your health information must include: (1) the desired form or format of access; (2) a description of the health information to which the request applies; and (3) appropriate contact information.

Cost: If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies we use to fulfill your request. The standard fee is $0.75 per page and must generally be paid before or at the time we give the copies to you.

Form and Format: If the information you request is stored electronically, we will provide the information in the form and format you request if the information is readily producible in that format, or, if not, we will reach an agreement with you as to alternative readable electronic format.

Response Time: We will respond to your request for inspection of records within 10 days. We ordinarily will respond to requests for copies within 30 days. If we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request.

If Your Request Is Denied: Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we may provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we will not let you inspect or copy.

2. Right To Amend Records

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records.

How to Make Your Request: To request an amendment, please write to HSS West Side ASC, Attn. Privacy Officer, 610 West 58th Street, New York, NY, 10065. A request to amend your health information must include a description of the amendment requested and should include the reasons why you think we should make the amendment.

Response Time: Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

If Your Request Is Denied: Your request for an amendment may be denied if you request an amendment of health information that we determine: (1) was not created by HSS West Side ASC, unless the originator of the health information is no longer available to make the amendment; (2) is not part of HSS West Side ASC's records; (3) is not health information that you would be permitted to inspect or copy; or (4) is accurate and complete. If we deny part, or all, of your request, we will provide a written notice that explains our reasons for doing so. You will have the

right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement, which we will include in your records. We will also provide you with information on how to file a complaint with us or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

3. Right To An Accounting Of Disclosures

You have a right to request an "accounting of disclosures" which identifies certain other persons or organizations to whom we have disclosed your health information in the previous six years in accordance with applicable law and the protections afforded in this Notice. An accounting of disclosures does not describe the ways that your health information has been shared within HSS West Side ASC, as long as all other protections described in this Notice have been followed (such as obtaining the required approvals before sharing your health information with our doctors for research purposes).

An accounting of disclosures also does not include information about the following disclosures:

- Disclosures we made to you or your personal representative;
- Disclosures we made pursuant to your written authorization;
- Disclosures we made for treatment, payment or health care operations;
- Disclosures made from the patient directory;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures that were incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by);
- Disclosures for purposes of research, public health or our health care operations of limited portions of your health information that do not directly identify you;
- Disclosures made to federal officials for national security and intelligence activities; and
- Disclosures about inmates to correctional institutions or law enforcement officers.

How to Make Your Request: To request an accounting of disclosures, please write to HSS West Side ASC, Attn. Privacy Officer, 610 West 58th Street, New York, NY, 10065. Your request must state a time period within the past six years for the disclosures you want us to include. You have a right to receive one accounting within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12 month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred. The scope of your right to request an accounting may be modified from time to time to comply with changes in federal law or state law.

Response Time: Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

4. Right To Request Additional Privacy Protections, Including Restriction on Disclosures to Health Plans

You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run our health care operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a surgery you had. In addition, you have the right to restrict certain disclosures of protected health information to a health plan where you pay, or another person on your behalf pays, out-of-pocket in full for the health care item or service.

How to Make Your Request: To request restrictions, please write to HSS West Side ASC, Attn. Privacy Officer, 610 West 58th Street, New York, NY, 10065. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply.

We are Not Always Required to Agree: We are not always required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. We do not need to agree to the restriction unless (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (ii) the health information relates only to a health care item or service that you or someone on your behalf has paid for out-of-pocket and in full. *However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law.* Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some

circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

5. Right To Request Confidential Communications

You have the right to request that we communicate with you about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. For example, you may ask that we contact you at home instead of at work.

How to Make Your Request: To request more confidential communications, please write to HSS West Side ASC, Attn. Privacy Officer, 610 West 58th Street, New York, NY, 10065. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests. Please specify in your request how or where you wish to be contacted, and how payment for your health care will be handled if we communicate with you through this alternative method or location.

6. Right To Notice of Breach of Unsecured Health Information

We are required by law to maintain the privacy of your health information, to provide you with this Notice containing our legal duties and privacy practices with respect to your health information, and to abide by the terms of this Notice. It is HSS West Side ASC's policy to safeguard your health information so as to protect the information from those who should not have access to it. If, however, for some reason we experience a breach of your unsecured health information, we will notify you of the breach.

MISCELLANEOUS

1. How Someone May Act On Your Behalf

You have the right to name a legal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors, unless the minors are permitted by law to act on their own behalf.

2. How to Learn About Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Some parts of this Notice may not apply to these types of information. If your treatment involves this information, you may be provided with special authorization forms in connection with the disclosure of such information by HSS West Side ASC. To request copies of these forms, please contact HSS West Side ASC at 212.774.7026.

3. How to Obtain a Copy of This Notice

You have the right to a paper copy of this Notice. You may request a paper copy at any time, even if you have previously agreed to receive this Notice electronically. To do so, please call HSS West Side ASC at 212.774.7026. You may also obtain a copy of this Notice from our website at www.hss.edu/HSS West Side ASC or by requesting a copy at your next visit.

4. How to Obtain a Copy of Revised Notice

We may change our privacy practices from time to time. If we do, we will revise this Notice so you will have an accurate summary of our practices, and the revised Notice will apply to all of your health information. We will post any revised Notice in our admitting areas and other locations in HSS West Side ASC. You will also be able to obtain your own copy of the revised Notice by accessing our website at www.hss.edu/asc, calling HSS West Side ASC at 212.774.7026, or asking for one at the time of your next visit. The effective date of the Notice will always be noted in the cover and at the top outside corner of the each page. We are required to abide by the terms of the Notice that is currently in effect.

5. How to File a Complaint

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. To file a complaint with us, please contact HSS West Side ASC's Privacy Officer at 212.774.7026 or send a letter to HSS West Side ASC, Attn. Privacy Officer, 610 West 58th Street, New York, NY, 10065. ***No one will retaliate or take action against you for filing a complaint.***

Acknowledgement of Receipt of Notice of Privacy Practices

Respect for our patients' privacy has long been highly valued at HSS West Side ASC. Not only is it what our patients expect, it is the right way to conduct health care. As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices that describes the health information privacy practices of HSS West Side ASC, its medical staff and affiliated health care providers when providing health care services for HSS West Side ASC. Our Notice will be prominently posted in HSS West Side ASC. You will also be able to obtain your own copy of the Notice by accessing our website at www.hss.edu/asc, calling HSS West Side ASC at 212.774.7026, or asking for one at the time of your next visit.

By signing below, I acknowledge that I have been provided a copy of this Notice and have therefore been notified of how health information about me may be used and disclosed by HSS West Side ASC, and how I may obtain access to and control this information. I also acknowledge and understand that special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information.

Patient Copy

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Date

If you have any questions about this Notice or would like further information, please contact HSS West Side ASC's Privacy Officer at 212.774.7026.

For Office Use Only: If the patient does not sign this acknowledgement form, record here the good faith efforts made to obtain this acknowledgement.

This page is your copy of the acknowledgement you were asked to sign when you were first given this Notice.

PATIENT IDENTIFIER SAFETY NOTICE

AT THE HSS West Side ASC WE TAKE PATIENT SAFETY VERY SERIOUSLY!

Patient Identifier Safety Notice

Your Legal ID & Date of Birth

For your safety, our policy is to use your name and date of birth only as it appears on the Legal ID presented at the time of your registration.

Approved Legal IDs in preferred order include:

- Driver's License
- Passport
- Birth Certificate
- Social Security Card
- Green Card/Permanent Resident Card
- Military ID

If you do not have the ID types that are listed above, please let us know at the time of your registration.

Each time you register, and/or check in, our team will verify your Legal ID by asking you to spell your first and last names and confirm your date of birth. Your physician will also confirm your identity.

Do not be concerned if your name appears differently on your insurance card. Our staff is trained to make the necessary adjustments in our computer system so that the insurance card name is used for billing purposes.

You play a part in safety too!! Place your safety reminders or notes here:

FINANCIAL ASSISTANCE POLICY

Financial Assistance Summary

The HSS West Side ASC has a Financial Assistance Program that assists certain patients with limited or no insurance coverage and who meet certain requirements. The Policy covers only medically necessary services, including HSS West Side ASC services and some services provided by certain HSS West Side ASC physicians and other employees of the HSS West Side ASC. The Policy will be applied consistently regardless of race, color, creed, sexual orientation, ethnic origin or immigration status.

Eligibility

In order to be eligible for Financial Assistance, individuals must meet both the Financial Criteria and Coverage Criteria.

In order to meet the Financial Criteria, your gross annual income must not exceed seven times the U.S. Department of Health and Human Services Poverty Guidelines. In order to meet the Coverage Criteria, you must be (i) an uninsured U.S. resident; (ii) an insured U.S. resident with coverage that covers services at HSS at least to some extent; or (iii) be referred through the Special Access Program.

Under the Special Access Program, insured U.S. residents in need of specialized care that is not reasonably available closer to their residence than HSS may be eligible. In addition, (i) insured U.S. residents and (ii) uninsured non-residents, in each case who are referred by an HSS Physician Hospital Organization (PHO) physician and meet other requirements contained in the full Policy, may be eligible.

How to Apply

Anyone requesting Financial Assistance must complete an application. The applicant should provide documentation that supports their family's current level of income, available assets, and demographic information. Documents that prove the current level of income can include pay stubs or Social Security or disability statements. If you cannot provide such items, you may still apply. All applications, supporting documentation, and communication will be treated confidentially.

HSS West Side ASC uses poverty guidelines issued by the U.S. Department of Health and Human Services to determine a patient's eligibility for financial assistance. The amount of the discount varies based on your income and the size of your family. The income limits based on seven times the 2019 Federal Poverty Guidelines (the "FPL") are below.

Family size	Annual Family Income	Monthly Family Income	Weekly Family Income
1	Up to $87,430	Up to $7,286	Up to $1,681
2	Up to $118,370	Up to $9,864	Up to $2,276
3	Up to $149,310	Up to $12,443	Up to $2,871
4	Up to $180,250	Up to $15,021	Up to $3,466
5	Up to $211,190	Up to $17,599	Up to $4,061
6	Up to $242,130	Up to $20,178	Up to $4,656
7	Up to $273,070	Up to $22,756	Up to $5,251
8	Up to $304,010	Up to $25,334	Up to $5,846

Effective January 2018

The applicant will be notified in writing of the determination within 30 calendar days of receipt of a complete application. You may disregard any bills while your application for a discount is being considered.

You may appeal our initial Financial Assistance determination -- the full policy provides a description of our appeals process.

Amount of Assistance

If your income is at or below 500% of the FPL and you are uninsured, care will be provided without charge. (If you are insured, your patient responsibility will be reduced to zero.)

For an individual whose income is between 501% and 700% of the FPL, HSS shall provide a 50% discount.

The discount will be applied to the patient's obligation, which, for uninsured patients, is based on the amount that Medicaid would pay for the service. For insured patients, the discount is applied to the deductible and copayment obligation. In no event will a patient who qualifies for Financial Assistance have out-of-pocket expense for the applicable care that exceeds the amount that the Hospital would generally bill based on Medicaid rates.

Availability of the Financial Assistance Policy

A copy of the Financial Assistance Policy and an application is available at **www.hss.edu/westsideASC**. You may request a copy of the Financial Assistance Policy and an application by email, phone, fax, or in person from:

HSS West Side ASC
Financial Assistance Program
535 East 70th Street
New York, NY 10021
Tel: 646.495.3300
Fax: 646.495.3301

The requested materials will be mailed without charge.

For more information about the HSS West Side ASC Financial Assistance Program, or for assistance with the application process, you may speak with a HSS West Side ASC Financial Assistance Associate who can be reached at the contact address, phone number, or location immediately above. Foreign language translation can be provided if requested. Completed applications should be submitted to the HSS West Side ASC Financial Assistance Program at the above address.

The HSS West Side ASC Financial Assistance Policy, application, and this Summary are also available in various foreign languages. Translators can be provided if requested.

Individuals who feel that the HSS West Side ASC Policy has not been applied in accordance with its terms should seek assistance from the HSS West Side ASC Department of Corporate Compliance and Internal Audit. Complaints should be directed to the HSS West Side ASC Corporate Compliance Officer at 646.495.3300 or the confidential HSS West Side Compliance Helpline at (888) 651-6234. If you have a complaint, you may also call the New York State Department of Health at (800) 804-5447.

HSS West Side ASC

610 West 58th Street
New York, NY 10019
212.774.7026