THE SURGICAL SUITE
PATIENT NOTIFICATION

The Surgical Suite would like to assure you of your rights and responsibilities as a patient.

YOU HAVE THE RIGHT TO:

*Considerate, respectful & dignified care provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
*All communications & records to be kept private & confidential, within the law.
*Information concerning your diagnosis, treatment, prognosis, risks & alternatives, as part of the informed consent process.
*You have a right to designate someone to represent you on your behalf.
*Appropriate assessment & management of pain.
*The opportunity to participate in decisions involving your medical care, unless contraindicated by the urgency of the case.
*Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
*Be advised & refuse to participate in any research without risk of compromising your right to access care, treatment or services.
*Know the identity and professional status of individuals providing service.
*Refuse treatment to the extent permitted by law & informed of the consequences of that action.
*Request a change in providers of care if other qualified providers are available.
*Expect reasonable continuity of care.
*To examine and receive an explanation of your bill.
*To consult with a specialist at your own request & expense.

PATIENT COMPLAINT OR GRIEVANCE

The Surgical Suite will promptly review, investigate & resolve any patient grievance/complaint in a timely manner. If you feel you have an issue, we provide you with the following contact information:
The Surgical Suite, 5555 Peachtree-Dunwoody Rd., Ste. 180 Atlanta, Georgia 30342 Attn: Administrator

Administrator: Sharon Williams 404-256-4457 Ext. 211
Fax: 404-969-0683

Georgia Composite Medical Board
2 Peachtree St., NW, 10th floor, Atlanta Georgia 30303-3465
www.medicalboard.georgia.gov

Office of Regulatory Services – Dept. of Human Resources
2 Peachtree St., NW, 10th floor, Ste., 33.458, Atlanta Georgia 30303-3142
www.ors.dhr.georgia.gov

Medicare beneficiaries may file a complaint with the Medicare Beneficiary Ombudsman at:
www.cms.hhs.gov

6/10

YOU HAVE THE RESPONSIBILITY FOR:

*Providing accurate & complete information about your present health status, present medications, past medical history & reporting any unexpected changes to your provider.
*Following the treatment plan recommended by your provider.
*Following the rules & regulations of The Surgical Suite affecting patient care & conduct.
*In the case of a pediatric patient, a parent or guardian is to remain in the facility for the duration of the patient's stay.
*Be considerate & respectful of the rights of other patients & facility personnel.
*Providing a responsible adult to transport you home after surgery; providing a responsible adult to care for you 24 hours after surgery with anesthesia
*Indicate whether you clearly understand the contemplated course of treatment and what is expected of you.
*Your actions if you refuse treatment; leave the facility against the advice of the doctor and/or do not follow the doctor's instructions relating to care.
*Assuring financial obligations of your care are fulfilled as expediently as possible.

HIPAA (Privacy & Confidentiality)

The Surgical Suite complies with federal Health Insurance Portability Accountability Act regulations to maintain the privacy of your health information.

ADVANCED DIRECTIVE

The Surgical Suite is not an acute care facility. If an adverse event occurs during your treatment, regardless of any advanced directive or instructions from a healthcare surrogate or attorney, we will initiate resuscitative or stabilizing measures & transfer you to an acute care setting for further evaluation. Your agreement with this policy DOES NOT revoke or invalidate any current healthcare directive or healthcare power of attorney.

Disclosure of ownership:

☐ Physician has financial interest in the facility

☐ Physician does not have financial interest in the facility

By signing this document, I acknowledge I have read, understand & agree to the contents.

Pt. Name/Number:_____

Patient Signature:_____

Date:_____ Time:_____