SEVEN HILLS
ASC

Dear Patient,

Please read and complete all forms attached **prior to the day of your procedure**. The following forms will become part of your permanent medical record and therefore are required to be completed and brought with you the day of your procedure.

Please be aware that if you are the legal guardian of the patient being seen, documentation (i.e. guardianship paperwork) will be **required** upon check in. Please be sure to bring this paperwork with you on the procedure date.

Please be sure to follow your physician's instructions on preparing for your procedure. Any instructions not followed could cause a delay or cancellation of your procedure.

PLEASE LEAVE ALL JEWELRY AND VALUABLES AT HOME, *EXCEPT*,

***Picture ID**

***Insurance card(s)**

***Any money owed** *(for co-payment/deductible/facility fee)*

We accept cash, check, credit cards, and Care Credit for payment.

Please feel free to contact us if you have any questions at (702) 914-2028

Thank you,

Seven Hills ASC

SEVEN HILLS
ASC

876 Seven Hills Dr. Henderson, NV 89052
Phone: 702.914.2028 Fax: 702.614.7456

PLEASE PRINT

PATIENT REGISTRATION

_____ AGE: _____ B/DATE: _____ /_____/_____ SEX: M F
Patient Name (Last, First, Middle)

_____
Street (Include Bldg #, Apt #, Space #) City State Zip Code

_____
Patient's email address

HOME # (_____) _____ CELL # (_____) _____ SOC. SEC. # _____ /_____/_____

MARITAL STATUS:_____ SPOUSE'S NAME _____

EMPLOYER NAME: _____ WK # (_____) _____ OCCUPATION:_____

_____
Street (Include Bldg #, Apt #, Space #) City State Zip Code

PRIMARY INSURANCE INFORMATION (Please Bring Card to Front Desk)

INS. NAME: _____ TEL # (_____) _____

_____
Street (Include Bldg #, Apt #, Space #) City State Zip Code

SOC. SEC. # _____ /_____/_____

INSURED/SUBSCRIBER NAME: _____ RELATIONSHIP: _____ B/DATE:_____

_____
SUBSCRIBER OR ID # GROUP NO # PLAN #/EMP NAME

SECONDARY INSURANCE INFORMATION (Please Bring Card to Front Desk)

INS. NAME: _____ TEL # (_____) _____

_____
Street (Include Bldg #, Apt #, Space #) City State Zip Code

SOC. SEC. # _____ /_____/_____

INSURED/SUBSCRIBER NAME: _____ RELATIONSHIP: _____ B/DATE:_____

_____
SUBSCRIBER OR ID # GROUP NO # PLAN #/EMP NAME

_____ HOME # (_____) _____ /_____
Nearest Relative Not Living With Patient

Relationship to Patient _____ CELL # (_____) _____ /_____

_____ HOME # (_____) _____ /_____
In Case of Emergency, Who Should Be Notified?

Relationship to Patient _____ CELL # (_____) _____ /_____

_____ **DATE:** _____
Signature of Patient or Legal Guardian

SEVEN HILLS ASC

ACKOWLEDGEMENTS

Ownership Disclosure

I am aware that my physician may have ownership interest in Seven Hills ASC.
I understand that I may choose another facility for the purpose of having the procedure
_____ performed.

I have decided to have my procedure performed at Seven Hills ASC. I acknowledge that I was
_____ notified in advance of the date of the procedure of this disclosure.

Patient Rights and Responsibilites

I acknowledge that I have received a copy of Seven Hills ASC's Patient Right's & Responsibilites in advance of the date of the procedure. I understand that I may address any questions
_____ that I have regarding this form to the facility's representative.

Advance Directives

I acknowledge that I have received a copy of Seven Hills ASC's policy on Advance Directives in advance of the date of the procedure. I understand that I may address any questions
_____ that I have regarding this form to the facility's representative.

Notice of Privacy Act

I acknowledge that I have received a copy of Seven Hills ASC's Notice of Privacy Practice in advance of the date of the procedure. I understand that I may address any questions
_____ that I have regarding this form to the facility's representative.

_____ _____
Patient (Patient Representative) Signature Date

_____ _____
Witness Date

Seven Hills ASC * 876 Seven Hills Drive * Henderson, NV 89052

Phone: 702.914.2028 * Fax 702.614.7456

SEVEN HILLS
ASC

876 Seven Hills Drive* Henderson, NV 89052*
Phone: 702.914.2028 * Fax 702.614.7456

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Thank you for choosing Seven Hills ASC as your healthcare provider. The following is our financial policy. If you have any questions or concerns about our payment policies, please do not hesitate to contact our Billing Department at (702) 914-2028.

Payment for services is due at the time services are rendered. We accept cash, check or credit card. We will submit an insurance claim on your behalf. You must notify us immediately if your insurance information changes.

You must understand and sign that you acknowledge the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company.
2. You have the right to waive your insurance at any time, If you do not inform us of your insurance carrier information at the time of service you could be responsible for all fees incurred at the time of service.
3. You are responsible for knowing your insurance benefits. What are non-covered services in your plan? What is your deductible and/or co-payments for outpatient surgery? Does your plan require a primary care physician (PCP) referral, or pre-authorization? If we can be of assistance, please let us know.
4. You are responsible for any deductible, co-insurance, or co-payment that will be applied to the surgery center at the time services are rendered. You may pay by cash, check, or credit card.
5. Returned checks are subject to a return check fee of $25.00.
6. A 1.5% interest rate may be added to any patient outstanding balance over 30 days.
7. Financial arrangements for services must be made through the Billing Department, prior to services being rendered. The Billing Department can be reached at (702) 914-2028.
8. If your account goes to Collections, you are responsible for any Collection fees, Legal fees and/or court fees.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance company to pay directly to Seven Hills ASC the amount due for Medical Benefits under this claim.

I hereby agree to pay Seven Hills ASC all charges not covered by my insurance company. I also agree that if any insurance payments are paid directly to me, I will pay Seven Hills ASC within 15 days of receiving the insurance payment.

MEDICARE-MEDICAL INSURANCE BENEFITS-SOCIAL SECURITY ACT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Ace about me, to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf.

RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of any medical information necessary to process my insurance claim(s) and request that the payment of all benefits be made to Seven Hills ASC for services described. I also authorize the release of any medical records to other physicians, insurance companies or acute care facilities for services needed in order to render necessary medical care pertaining to my services with Seven Hills ASC.

I hereby acknowledge that I have read and understand the above material and agree to the terms.

_____ _____

Patient (Patient Representative) Signature Date

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ASC

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance company to pay directly to Seven Hills ASC the amount due for Medical Benefits under this claim.
I hereby agree to pay Seven Hills ASC all charges not covered by my insurance company. I also agree that if any insurance payments are paid directly to me, I will pay Seven Hills ASC within 15 days of receiving the insurance payment.

_____ _____
Patient (Patient Representative) Signature Date

MEDICARE-MEDICAL INSURANCE BENEFITS-SOCIAL SECURITY ACT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Ace about me, to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf.

_____ _____
Date of Service HIC/Medicare No.

_____ _____
Patient (Patient Representative) Signature Date

RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of any medical information necessary to process my insurance claim(s) and request that the payment of all benefits be made to Seven Hills ASC for services described. I also authorize the release of any medical records to other physicians, insurance companies or acute care facilities for services needed in order to render necessary medical care pertaining to my services with Seven Hills ASC.

_____ _____
Patient (Patient Representative) Signature Date

Seven Hills ASC-876 Seven Hills Drive- Henderson, NV 89052
Phone: 702.914.2028 – Fax:702.614.7456

MEDICATION RECONCILIATION SHEET

Patient Stated Home Medications (including herbal and over the counter drugs):

SEVEN HILLS ASC

Medication	Dosage	Frequency/ Route	Date/Time Last taken	Reason for Medication

☐**Physician Order to Continue all Previously Noted Medications.** *Medications NOT RELATED to the surgery are to be reviewed between patient and their PCP*

☐_____ **Med History & Dosages were recalled to the best of patient's ability**

_____

Date **Pre-OP RN Signature**

Added Prescription Medications

Medication	Dosage	Frequency/ Route	Next Dose	Reason for Medication	RX given to pt
					☐yes ☐prior ☐called in
					☐yes ☐prior ☐called in

I have received a copy of my reconciled medication list at discharge from Seven Hills ASC. I understand that I am responsible for the confidentiality of this list. I have been instructed to update my medication list accordingly, when meds are changed, discontinued, or added, including any over-the-counter medications. Furthermore, I acknowledge the need to advise and discuss any medication changes with my PCP.

_____ _____

Date **Patient or Responsible Party** **Date** **Discharge RN Signature**

☐ **Medication List reconciled with patient and ride upon Discharge**

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INSTRUCTIONS: Please indicate by a checkmark (√) you answer to each question. These answers will greatly help us to give you the best possible care during your procedure. If you do not know an answer, please indicate by a question mark (?). If there are multiple answers, please circle the appropriate one. Be specific, and explain if necessary.

AGE _____ SEX _____ HEIGHT _____ WEIGHT _____

MEDICATION ALLERGIES _____ Reaction _____

ARE YOU ALLERGIC TO LATEX? Yes No Reaction: _____

Have you or anyone in your family had an unusual reaction to Anesthesia? Yes No Explain: ____

_____

Are you taking any medications, including blood thinners (Aspirin, Ibuprofen, Plavix, Coumadin, etc.) ___

_____

***Please complete the MEDICATION RECONCILIATION SHEET that is included in this packet.**

Are you taking any herbal medications? Yes No

Please list: _____

Have you had or do you still have? If yes, when?	Yes	No
1. Are you a diabetic?	☐	☐
2. Do you have a cold?	☐	☐
3. Bronchitis or chronic cough?	☐	☐
4. Asthma?	☐	☐
5. Emphysema?	☐	☐
6. Shortness of Breath?	☐	☐
7. Any other Lung trouble?	☐	☐
If yes, explain: _____		
8. Do you smoke? How much _____day?	☐	☐
9. Rheumatic Fever?	☐	☐
10. Heart Murmur?	☐	☐
11. Any heart valve problems?	☐	☐
12. High Blood Pressure?	☐	☐
13. Do you have a pacemaker? Rate _____	☐	☐
14. Chest Pain/Angina?	☐	☐
15. Heart Attack(s)?	☐	☐
16. Palpitations: Irregular or fast heartbeat?	☐	☐
17. Any blood diseases? _____	☐	☐
18. Jaundice, Hepatitis, Liver Trouble?	☐	☐
19. Gallbladder trouble?	☐	☐
20. Do you drink alcoholic beverages?	☐	☐
How much alcohol/beer in a week? _____		
21. Gastric-esophageal problems?	☐	☐
22. Reflux-frequent indigestion?	☐	☐
Hiatal Hernia?		
23. Seizure disorder?	☐	☐
24. Neurological problems?	☐	☐
Stroke, Paralysis, severe head injury		
25. Head or neck injury or surgery?	☐	☐

	Yes	No
26. Back trouble?	☐	☐
If yes, for how long? _____		
27. Kidney trouble?	☐	☐
28. Thyroid trouble?	☐	☐
29. Any history of street drug Use?	☐	☐

30. Have you had surgery before? If yes, Check list below:

☐ Appendectomy	☐ Hysterectomy
☐ Breast/Biopsy	☐ Orthopedic _____
☐ Cataracts	☐ Sinus/Nasal
☐ Gallbladder	☐ Tonsils/Adenoids
☐ Hernia	☐ Other

_____

_____

31. Any illness or disease not listed? _____

_____

Please list any information you feel would be Helpful in your care:

_____

_____

_____

Date: _____

Signature: _____

Cell Phone Number: _____

Patient Label

SEVEN HILLS
ASC

Seven Hills ASC is committed to providing the highest level of patient care. To achieve this objective, we would like to sincerely ask our patients, or their caregiver, to assist us by completing a brief **Patient Satisfaction Survey** after their surgery.

To better serve you, we have automated this process to provide you with two different options in completing a survey. Within 48 hours after your surgery, you will receive an email with a link to our patient satisfaction survey. This survey can be completed online, and you may even keep your comments anonymous, if desired. Our survey results are administered through an independent third party that compiles our data for us and reports any issues that might be identified as an opportunity to improve future patient's experiences.

As a second option, we are happy to provide you with a self-addressed, stamped paper survey which is forwarded to the same third party company to enter for you, if you desire.

Please rest assured, that your personal information is protected and kept private. It is, in no way, used for anything other than improving patient satisfaction. We are committed to providing you with confidentiality of your private medical information.

Sincerely,

Seven Hills ASC

Please enter your email address below:

FAQs
(frequently asked questions)

about
"Surgical Site Infections"

What is a Surgical Site Infection (SSI)?

A surgical site infection is an infection that occurs after surgery in the part of the body where the surgery took place. Most patients who have surgery do not develop an infection. However, infections develop in about 1 to 3 out of every 100 patients who have surgery.

Some of the common symptoms of a surgical site infection are:

- Redness and pain around the area where you had surgery
- Drainage of cloudy fluid from your surgical wound
- Fever

Can SSIs be treated?

Yes. Most surgical site infections can be treated with antibiotics. The antibiotic given to you depends on the bacteria (germs) causing the infection. Sometimes patients with SSIs also need another surgery to treat the infection.

What are some of the things that hospitals are doing to prevent SSIs?

To prevent SSIs, doctors, nurses, and other healthcare providers:

- Clean their hands and arms up to their elbows with an antiseptic agent just before the surgery.
- Clean their hands with soap and water or an alcohol-based hand rub before and after caring for each patient.
- May remove some of your hair immediately before your surgery using electric clippers if the hair is in the same area where the procedure will occur. They should not shave you with a razor.
- Wear special hair covers, masks, gowns, and gloves during surgery to keep the surgery area clean.
- Give you antibiotics before your surgery starts. In most cases, you should get antibiotics within 60 minutes before the surgery starts and the antibiotics should be stopped within 24 hours after surgery.
- Clean the skin at the site of your surgery with a special soap that kills germs.

What can I do to help prevent SSIs?

Before your surgery:

- Tell your doctor about other medical problems you may have. Health problems such as allergies, diabetes, and obesity could affect your surgery and your treatment.
- Quit smoking. Patients who smoke get more infections. Talk to your doctor about how you can quit before your surgery.
- Do not shave near where you will have surgery. Shaving with a razor can irritate your skin and make it easier to develop an infection.

At the time of your surgery:

- Speak up if someone tries to shave you with a razor before surgery. Ask why you need to be shaved and talk with your surgeon if you have any concerns.
- Ask if you will get antibiotics before surgery.

After your surgery:

- Make sure that your healthcare providers clean their hands before examining you, either with soap and water or an alcohol-based hand rub.

  If you do not see your providers clean their hands, please ask them to do so.

- Family and friends who visit you should not touch the surgical wound or dressings.
- Family and friends should clean their hands with soap and water or an alcohol-based hand rub before and after visiting you. If you do not see them clean their hands, ask them to clean their hands.

What do I need to do when I go home from the hospital?

- Before you go home, your doctor or nurse should explain everything you need to know about taking care of your wound. Make sure you understand how to care for your wound before you leave the hospital.
- Always clean your hands before and after caring for your wound.
- Before you go home, make sure you know who to contact if you have questions or problems after you get home.
- If you have any symptoms of an infection, such as redness and pain at the surgery site, drainage, or fever, call your doctor immediately.

If you have additional questions, please ask your doctor or nurse.

Co-sponsored by:

SHEA The Society for Healthcare Epidemiology of America
IDSA
American Hospital Association
APIC Spreading knowledge. Preventing infection.
CDC Centers for Disease Control and Prevention
The Joint Commission

SEVEN HILLS
ASC

PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

This facility and medical staff have adopted the following statement of patient rights. These rights are provided to the patient or the patient's representative (as allowed under state law). These rights shall include, but not be limited to, the patient's right to:

- Become informed of his/her rights as a patient in advance of, or when discontinuing the provision of care. The patient may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.
- Considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
- Have his/her cultural, psychosocial, spiritual and personal values, beliefs and preferences respected. To assure these preferences are identified and communicated to staff, a discussion of these issues will be included during the initial nursing admission assessment.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Remain free from seclusion or restraints of any form that are not medically necessary or are used as means of coercion, discipline, convenience or retaliation by staff.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of the other physicians and healthcare providers who will see him/her.
- Receive information from his/her physician about his/her illness, health status, diagnosis, course of treatment, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she or the patient's representative can understand.
- Receive information about any proposed treatment or procedure he/she may need in order to participate in the development of the plan of care, give informed consent or refuse the course of treatment and to participate in planning for care after discharge.
    - Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Formulate advance directives regarding his/her healthcare, and to have facility staff and practitioners who provide care in the facility comply with these directives (to the extent provided by state laws and regulations).
- Have a family member or representative of his/her choice notified promptly of his/her visit to the facility, if requested.
- Have his/her personal physician notified promptly of his/her visit to the facility.
- Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to reason for the presence of any individual involved in his or her healthcare.

- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communication specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his/her medical record within a reasonable time frame (usually within 48 hours of request).
- Reasonable responses to any reasonable request he/she may make for service.
- Leave the facility even against the advice of his/her physician.
- Reasonable continuity of care.
- Be advised of grievance process, should he/she wish to communicate a concern regarding the quality of the care he/she receives. Notification of the grievance process includes: whom to contact to file a grievance, and that he/she will be provided with a written notice of grievance determination that contains the name of the facility contact person, the steps taken on his/her behalf to investigate the grievance, the results of the grievance and the grievance completion date.
- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/ or trial clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form (s).
- Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge.
- Examine and receive and explanation of his/her bill regardless of source of payment.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient's rights apply to the person who may have a legal responsibility to make decisions regarding medical care on behalf of the patient.

PATIENT RESPONSIBILITIES

The care a patient receives depends partially on the patient himself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit on mutual trust and respect.

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health.
- The patient is responsible for reporting perceived risks in his/her care and unexpected changes in his/her condition to the responsible practitioner.
- The patient and family are responsible for asking questions about the patient's condition, treatments, procedures, clinical laboratory and other diagnostic test results.
- The patient and family are responsible for immediately reports any concerns or errors they may observe.
- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
- The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her facility care are fulfilled as promptly as possible.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.

NOTICE OF ADVANCE DIRECTIVES

Seven Hills ASC strives to provide an atmosphere of respect and caring and to ensure that each patient's ability and right to participate in medical decision-making is maximized and not compromised as a result of admission for care to this facility.

It is the policy of Seven Hills ASC to respect and encourage patient self-determination. Patients will be encouraged and assisted to be active participants in decision-making process regarding their care through education, inquiry and assistance as requested. Specifically, if a patient chooses whether to accept, reject, or continue medical care and treatment.

Seven Hills ASC provides a limited scope of services, specially limited to interventional surgical services and accompanying ancillary services. Further, the administration of medications that produce deep sedation necessarily involves some practices and procedures that might be viewed as "resuscitation" in other settings. Thus, a patient who does not desire to have a "do not resuscitate" order suspended shall not be a candidate for treatment at the facility and it shall be a condition of treatment at the facility that each patient suspend any "do not resuscitate" order that an otherwise valid and existing advance directive order might contain. In consenting to performance of surgical procedure at Seven Hills ASC, the patient will consent to the full suspension of existing directives during the aesthetic and immediate postoperative period and shall consent

In consenting to performance of surgical procedure at Seven Hills ASC, the patient will consent to the full suspension of existing directives during the aesthetic and immediate postoperative period and shall consent to the use of any resuscitation procedures that may be appropriate to treat clinical events that occur during this time. If rescue is required during procedure and a surrogate requests that a patient not be resuscitated, the surrogate will be informed of the policy of the facility to resuscitate patients in all circumstances.

Seven Hills ASC is an Outpatient Ambulatory Surgical Facility and is therefore not required by law to obtain Advance Directives on all patients. If a patient requires about Advance Directives, information or a resource for acquiring information will be provided to the patient.

Information regarding obtaining or initiating Advance Directives is available at our facility. Please inquire though the Registration Department. Thank you

A request of the patient/significant other to provide a copy of the Advance Directive for medical record entry will be made by Admitting Department during the admission process. Information regarding the suspension of advance directives will be provided to the patient upon each admission to Seven Hills ASC.

SEVEN HILLS ASC

NOTICE OF PRIVACY PRACTICE

This document defines your Privacy Rights at Seven Hills ASC as mandated by the Health Insurance Portability and Accountability Act pf 1996 (HIPPA)

EFFECTIVE APRIL 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Seven Hills ASC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at Seven Hills ASC, please see the contact information at the end of this document.

I. HOW SHSC MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

Seven Hills ASC collects and protects the privacy of your health information. The law permits Seven Hills ASC to use or disclose your health information for the following purposes:

1. **TREATMENT:** Seven Hills ASC may use your health information to provide you with medical treatment or services. For example, information obtained from you by a front office personnel or nurse is necessary to determine what treatment you should receive.
2. **PAYMENT:** Seven Hills ASC may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, your health information may be sent to a third-party payer such as an insurance company or health plan in order for Seven Hills ASC to receive payment for services rendered.
3. **HEALTH CARE OPERATIONS:** Seven Hills ASC may use and disclose health information about your operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to: evaluate the performance of our staff; asses the quality of care and outcomes in your cases and similar cases; and to determine how to continually improve the quality and effectiveness of health care we proved.
4. **INFORMATION PROVIDED TO YOU AND ON YOUR AUTHORIZATION:** You may give us written authorization to use or disclose your health information.
5. **NOTIFICATION AND COMMUNICATION WITH FAMILY:** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. **REQUIRED BY LAW:** As required by law, we may use and disclose your health information. For example, Seven Hills ASC may disclose health information for the following reasons: judicial and administrative proceedings; to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes; to the Department of Health and Human Services to determine if we are in compliance with federal laws; or to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety or a particular person or the general public.
7. **PUBLIC HEALTH:** As required by law, we may disclose your health information to public health authorities for purposes related: preventing or controlling disease, injury or disability; report child abuse or neglect; reporting

domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; to aid with disaster relief; and reporting disease or infection exposure.

8. **HEALTH OVERSIGHT ACTIVIVITIES:** We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
9. **DECEASED PERSON INFORMATION AND ORGAN DONATION:** We may disclose your health information to coroners, medical examiners, funeral directors, or to organizations involved in procuring, banking or transplanting organs and tissues.
10. **RESEARCH:** We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.
11. **WORKER'S COMPENSATION:** We may disclose your health information as necessary to comply with worker's compensation laws.
12. **MARKETING:** We may contact you to give you information about treatments or health-related benefits and services that may be of interest to you.
13. **GOVERNMENT FUNCTIONS:** Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use of disclosure of your health information.
14. **APPOINTMENTS:** Seven Hills ASC may use your information to provide appointment reminders by phone, email, or postal services.
15. **BUSINESS ASSOCIATES:** We work with other businesses to help Seven Hills ASC operate successfully. We may disclose your health information to these business associates so that they can perform the tasks we hired them to do. Our business associates must guarantee us that they will respect the confidentiality of your personal health information.

II. WHEN SEVEN HILLS ASC MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in this Notice of Privacy Practices, Seven Hills ASC will not use or disclose your health information without your written authorization.

III. YOUR HEALTH INFORMATION RIGHTS

1. You have the right to request restriction on certain uses and disclosures of your health information. Seven Hills ASC is not required to agree to the restriction that you requested.
2. You have the right to receive your health information through a reasonable alternative means or that at an alternative location. Requests must be made in writing detailing the alternative methods chosen and could be applicable to fees.
3. You have the right to inspect and/or obtain a copy of your health information for a reasonable fee.
4. You have the right to request that Seven Hills ASC amend your health information that is incorrect or incomplete. Seven Hills ASC is not required to change your health information and will provide you with information about the denial process.
5. You have a right to receive an accounting of disclosures of your health information made by Seven Hills ASC, except that Seven Hills ASC does not have to account for the disclosures described in treatment, payment, health care operations, and government functions of section I of this Notice. The first accounting of disclosures within a twelve-month period is free. Any additional accountings in that time frame are subject to a fee.
6. You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken/
7. You have a right to obtain a paper copy of this Notice upon request.

IV. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

Seven Hills ASC reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, Seven Hills ASC is required by law to comply with this Notice. A paper copy of this Notice is available if you request a copy.

V. COMPLAINTS

If you believe your privacy rights have been violated, or if you have complaints about this Notice of Privacy Practices contact.

PRIVACY OFFICER
SEVEN HILLS ASC
876 SEVEN HILLS DR
HENDERSON NV 89052
(702) 914-2028

If you are not satisfied with the manner in which Seven Hills ASC handles a complaint, you may submit a formal written complaint to the Department of Health and Human Services, Office for Civil Rights. You will not be retaliated against for filing a complaint.