

# OSSC

## OUTPATIENT SURGICAL SPECIALTIES CENTER<sup>LLC</sup>

Dear Patient:

Thank you for scheduling your procedure at Outpatient Surgical Specialties Center. Our Physicians designed this center with their patients in mind and we are proud to serve you. OSSC is a state licensed and Medicare certified ambulatory surgical center that is privately owned and operated by the physicians. OSSC is committed to meeting the needs of those we serve and our goal is to afford the community access to quality health care in a comfortable and cost-effective environment.

Please find enclosed the pre-registration paperwork. We ask that you fill these forms out in their entirety and bring them with you to your procedure. There are additional forms that will need to be signed the day of the procedure, so please bring your eyeglasses if applicable. A nurse will be calling you prior to your procedure to go over a medical questionnaire. At that time, they will discuss any specific pre-operative orders and answer any questions you may have. You may also receive a call from the business office to discuss your insurance benefits and answer any questions you may have related to our financial policies.

With regards to your insurance, OSSC has strived to be in-network with most insurance companies. However, if the circumstance arises and we are not a participating provider, please be assured that you will not incur any additional costs or penalties from using our facility. It is the policy of OSSC to extend "in-network benefits" to all of our patients regardless of the actual network. Enclosed in this packet is an acknowledgment form explaining our financial policies.

If you have any questions or concerns, please do not hesitate to call our office at (402) 691-1575 between the hours of 8:00am – 5:00pm Monday-Friday.

- Please bring your insurance card(s) and a photo ID with you along with any eyeglasses, if applicable.
- Nebraska law requires a guardian if the patient is below the age of 19.
- If you are having a Pain Management procedure, we request that your ride stays at our facility, as these are rather quick procedures.
- With respect to other patients and due to limited space, we ask that you limit the number of waiting family members.

Thank you in advance as we appreciate the opportunity to serve your healthcare needs.

*Outpatient Surgical Specialties Center, LLC*

11704 West Center Road Suite 110 Omaha, NE 68144  
Phone 402-691-1575 Fax 402-691-1599  
[www.outpatientsurgeryomaha.com](http://www.outpatientsurgeryomaha.com)

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## OUTPATIENT SURGICAL SPECIALTIES CENTER<sup>LLC</sup>

### Patient Bill of Rights

1. The patient has the right to respectful, considerate, and safe care by competent personnel.
2. The patient has the right to obtain in advance from his or her physician complete and current information about diagnosis, treatment, related risks, and prognosis in easily understandable terms. If it is medically inadvisable to give such information to the patients, it will be given to a legally authorized representative.
3. The patient has the right to receive from his or her physician information necessary to give informed consent prior to the start of any procedure or treatment. Except in emergencies this will include, but not necessarily limited to, a description of the specific procedure or treatment, any risks involved, and the probable duration of any incapacitation.
4. The patient has the right to accurate and easily understood information about their health care. If the patient speaks another language, has a physical or mental disability, help will be provided so the patient can make informed health care decisions.
5. The patient has the right to formulate advance directives and to understand that Outpatient Surgical Specialties Center will not comply with the directives but to understand that the directives will be transported with the patient if the patient requires hospitalization.
6. The patient has the right to change physicians and/or refuse care and treatment to the extent permitted by law, and has the right to be informed of the medical consequences of these actions including discharge from the facility. If discharge would jeopardize the patient's health, he or she has the right to remain under Outpatient Surgical Specialties Center's care until discharge or transfer is medically advisable.
7. The patient has the right to personal privacy and that all communications and records pertaining to care will be treated as confidential to the extent permitted by law.
8. The patient has the right to be free from abuse, neglect, and exploitation.
9. The patient has the right to access information contained in his or her medical record within a reasonable time when requested.
10. The patient has the right to receive surgical services without discrimination based upon race, color, religion, gender, national origin, or payer.
11. If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf. If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.
12. The patient has the right to voice complaints and grievances without discrimination or reprisal and have those complaints and grievances addressed.

Please voice any complaints and/or grievances to the Administrator, by phone at (402) 691-1575, by fax at (402) 691-1599, by email at [leppenbach@osscomaha.com](mailto:leppenbach@osscomaha.com), or by mail at Outpatient Surgical Specialties Center LLC, 11704 W. Center Road Suite 110, Omaha, NE 68144.

If your complaint or grievance is not resolved to your satisfaction, please contact the Administrator at The Department of Health and Human Services Regulation and Licensure Unit at P.O. Box 95986, Lincoln, NE 68509-5986. Phone: (402) 471-0316, Fax: (402) 471-0555.

The Office of Medicare Beneficiary Ombudsman's Website is <http://www.cms.hhs.gov/ombudson/resources.asp>

## NOTICE OF PRIVACY PRACTICES

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 6, 2007 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Leah Eppenbach. Information on contacting us can be found at the end of this Notice.

### TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law (court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

## **YOUR PRIVACY RIGHTS AS OUR PATIENT**

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$0.50 for each page and the staff time charged will be \$20.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

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## **QUESTIONS AND COMPLAINTS**

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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## **HOW TO CONTACT US**

Practice Name: Outpatient Surgical Specialties Center, LLC  
Privacy Officer: Leah Eppenbach  
Telephone: 402-691-1575  
Fax: 402-691-1599  
Email: [leppenbach@osscomaha.com](mailto:leppenbach@osscomaha.com)  
Address: 11704 W. Center Rd. Suite 110  
Omaha, NE 68144

**Outpatient Surgical Specialties Center, LLC**  
**Medication/Discharge Form**

Office Use Only  
(Patient Label)

Please complete the following and **bring back** on your scheduled procedure date.

**ALLERGIES:** Circle one: **YES** or **NO** If Yes, please list below:

Source:	Reaction:	Source:	Reaction:
1.		4.	
2.		5.	
3.		6.	

[illegible]

**Patient/Guardian Signature:** \_\_\_\_\_

**Date:**\_\_\_\_\_

**Do not write below this line. Staff ONLY!**

### Discharge Instructions:

- ☐ The medication(s) you were taking prior to your procedure have been noted.
- ☐ Based on your procedure today, there should be no changes to your home medications. If you have any questions, please contact your primary care physician.
- ☐ \*Please note the following Discharge Changes to your home medications:

- ☐ NEW Medication Instructions:

- ☐ If you have any questions about medications NOT prescribed by \_\_\_\_\_, please contact your primary care physician.

- ☐ Please provide your primary care physician a copy of this form.

MD/RN Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## OUTPATIENT SURGICAL SPECIALTIES CENTER, LLC

### **FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT**

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. If you have any questions or concerns about our policies, please do not hesitate to ask our Billing Department, Business Office Manager or Nurse Administrator.

We will submit an insurance claim for the facility's fee on your behalf. You must notify us immediately, if your insurance information changes. Under most circumstances, your insurance carrier will mail payments and correspondences directly to our office. In the event that your insurance carrier mails a payment to you, we ask that forward the payment to us by endorsing the check and writing "payable to OSSC" under your signature.

**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 are responsible for any deductible, co-payment or coinsurance that will be applied to Outpatient Surgical Specialties Center's charges at the time services are rendered. You may pay by cash, check, Visa or MasterCard.
3. You have the right to waive your insurance at anytime. If you do not inform us of your insurance information at the time of service, you are voluntarily waiving your right to use your insurance. You will be responsible for all fees incurred at the time of service.
4. You are responsible for knowing your insurance benefits. What are non-covered services in your plan? What your deductible, co-payment or coinsurance is for out-patient surgery? Does your plan require a Primary Care Physician (PCP) referral? If we can be of any assistance, please let us know.
5. If your insurance carrier does not pay in full within 30 days, our billing department will contact them. If your insurance carrier does not pay in full within 60 days; the charges will be transferred to your responsibility, and start accruing interest charges. We require you to pay the balance due with cash, check or credit card, even though your insurance carrier may eventually process the claim. At that time, any overpayment will be reimbursed.
6. Returned checks are subject to a return check fee of \$25.00
7. Financial arrangements for services must be made prior to services being rendered through the Office Manager or Nurse Administrator.
8. Patient balances over thirty days old are subject to additional interest charges.
9. If your account goes to Collections, you are responsible for any Collection fees, Legal fees or Court costs.

**If you have any questions or concerns please contact our Billing Department so that we can assist you in the management of your account.**

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

11704 West Center Road Suite 110 Omaha, NE 68144  
Phone 402-691-1575 Fax 402-691-1599

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## OUTPATIENT SURGICAL SPECIALTIES CENTER<sup>LLC</sup>

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
*Please print your name here*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

#### FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (*Please provide specific details*)

\_\_\_\_\_  
*Employee signature*

\_\_\_\_\_  
*Date*

11704 West Center Road Suite 110 Phone 402-691-1575 Fax 402-691-1599

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices  
*This form does not constitute legal advice and covers only federal, not state, law.*