

# ORAL REHAB BOOKING INFORMATION



Patient Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

                    Last                      First                      Middle

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female  \_\_\_\_\_

Home Address: \_\_\_\_\_

                    Street                                      City                                      State                      Zip

*(Pennsylvania State Required Questions)*

Race:  Black or African American  White  Asian  Native Hawaiian or Other Pacific Islander  
 American Indian or Alaska Native  Other \_\_\_\_\_  Unknown / Declined

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown / Declined

## Parent/Guardian Information

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address:  Same as above                      Address:  Same as above

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

Relationship to child:  Mother  Father  \_\_\_\_\_ Relationship to child:  Mother  Father  \_\_\_\_\_

*If you are other than the natural mother or father and have legal responsibility for the child, we require a copy of the document appointing you legally responsible. Only the legally responsible party can sign the Consent for Anesthesia and Conditions of Admission on the day of surgery.*

## Child's MEDICAL Insurance Information

Primary MEDICAL Insurance:

Secondary MEDICAL Insurance

Insurance Company: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber: \_\_\_\_\_

ID#: \_\_\_\_\_ ID#: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

I certify that the insurance(s) listed here represents all coverage(s) in place as of today.

I have received copies of Red Lion Surgicenter (1) Pre-op Instructions (2) Notice of Privacy Practices (3) Policies and Procedures (4) Advanced Directive Notice (5) Consent of Financial Responsibility (6) Missed Appointment Policy (7) Disclosure of Ownership (8) Patients' Rights & Responsibilities

\_\_\_\_\_  
Signature (Parent/Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name (Parent/Guardian)

Relationship to Child:  Mother  Father  \_\_\_\_\_

**Please return completed paperwork to the office, fax to (215)405-2528, or email to [redlion@cavitybusters.com](mailto:redlion@cavitybusters.com)**

# PEDIATRIC HEALTH HISTORY QUESTIONNAIRE



Patient Name: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Care Physician (Pediatrician): \_\_\_\_\_

Primary Care Physician (Pediatrician) Phone #: \_\_\_\_\_

**PLEASE CHECK ANY BOXES THAT APPLY TO YOUR CHILD'S MEDICAL HISTORY**  
**(INCLUDE ADDITIONAL DETAILS WHEN APPLICABLE)**

**Airway issues:**

- severe snoring (sleep apnea)
- \_\_\_\_\_

**Lung issues:**

- moderate-severe asthma
  - hospitalized for asthma within the past 3 months
  - acute flare-up of asthma within the past month
  - steroid-dependent
- \_\_\_\_\_

**Congenital heart or cardiac disease:**

- \_\_\_\_\_

**Endocrine/Metabolic/Genetic issues:**

- \_\_\_\_\_

**Gastrointestinal issues:**

- \_\_\_\_\_

**Musculoskeletal issues:**

- \_\_\_\_\_

**Hematologic/Oncologic issues:**

- Bleeding disorder
- family history of bleeding tendency
- \_\_\_\_\_

**Neurologic issues:**

- \_\_\_\_\_

**Miscellaneous allergies or sensitivities:**

- Pseudocholinesterase deficiency
- malignant hyperthermia (confirmed or "susceptible" by history)
- \_\_\_\_\_

**Previous Surgery/Family History**

- history of difficult or complicated intubation
- family history of major problems with surgery or anesthesia
- direct maternal Venezuelan ancestry

**NONE APPLY TO MY CHILD**

Other Important Medical Information: \_\_\_\_\_

List all medications the patient is presently taking:  None \_\_\_\_\_

List all previous surgery:  None \_\_\_\_\_

List all allergies (food, drug, other substances):  None \_\_\_\_\_

Do you have anything specific you want to discuss with the Anesthesiologist? \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

# RED LION SURGICENTER

240 Geiger Road Philadelphia, PA 19115 (215) 676-2232 Fax (215) 676-7130

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## Authorization to Release Information

I hereby give permission to Red Lion Surgicenter to obtain medical information regarding:

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I understand that these records will be utilized to schedule my child in the Red Lion Surgicenter to have all his/her dental treatment performed.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

Relationship to patient:  Mother  Father  \_\_\_\_\_

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Dear Doctor:

Our most recent dental examination revealed multiple carious teeth (ICD #521.0), and acute stress reaction (ICD #308.9) and a child totally incapable of safely receiving dental treatment in the office. Due to the extensive nature of the dental disease and the child's inability to tolerate treatment in the regular out-patient setting, we feel it would be in this child's best medical interest to perform treatment under general anesthesia. Further, since we believe in the care of the total child, we follow the policies with respect to protection of the developing psyche which have been adopted by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry. It is in this child's best medical interest to be treated under general anesthesia.

The Red Lion Surgicenter is a free-standing, state-of-the-art, beautiful facility just off of Red Lion Road in Northeast Philadelphia. It is comprised of 3 Class C operating rooms (meaning full general anesthesia and/or sedation), a 6 bed PACU and a 3 bed step-up/step-down unit. Red Lion Surgicenter was the first Ambulatory Surgical Center in the nation dedicated to treating children and adults with special needs for dental care. Over 3000 pediatric cases are performed successfully every year.

Patient selection is reviewed and approved by an Anesthesiologist. All care is overseen by an Anesthesiologist and Certified Registered Nurse Anesthetist (CRNA) who are present at all times, from sedation to discharge. Our medical staff and nursing staff are ACLS/PALS certified.

The information you provide on the history and physical form will be utilized by the Pediatric Anesthesiologist to determine the safest method of treatment to accomplish our goals of completing comprehensive dental care.

Thank you in advance for your cooperation,

Joshua A. Bresler DMD  
Medical Director, Red Lion Surgicenter



**HISTORY AND PHYSICAL  
EVALUATION**

Red Lion Surgicenter is a Pennsylvania Department of Health & AAAHC certified Ambulatory Surgery Center. It was the first ambulatory surgery center in the nation dedicated to providing dental care under general anesthesia for children and adults with special needs. All anesthesia is provided by Board Certified Anesthesiologists. Pennsylvania law requires a history and physical within 30 days of treatment in an ambulatory center. Please complete this form and return it to the patient for forwarding to the Surgicenter or mail/fax the completed form to the address provided above. Thank you for participating in this patient's care.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Pre-Op Diagnosis: Multiple Carious Teeth, Acute Stress Reaction Proposed Procedure(s): Oral Rehab

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Current Specialists:  Cardiology  Neurology  Hematology  Other: \_\_\_\_\_ \*Please include relevant reports\*.

PAST MEDICAL HISTORY (include pulmonary, cardiac, psych) \_\_\_\_\_

PAST SURGICAL HISTORY \_\_\_\_\_

**PHYSICAL EXAM**

HT: \_\_\_\_\_ WT: \_\_\_\_\_ AGE: \_\_\_\_\_ BP: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_

General Appearance: \_\_\_\_\_

<u>Check Box If No Significant Findings</u>	<u>Describe Abnormal Findings</u>
<input type="checkbox"/> HEENT	_____
<input type="checkbox"/> Lungs	_____
<input type="checkbox"/> Heart	_____
<input type="checkbox"/> GI/AB	_____
<input type="checkbox"/> GU	_____
<input type="checkbox"/> Back	_____
<input type="checkbox"/> Extremities	_____
<input type="checkbox"/> Neuro	_____

DATA (labs, EKG, etc.) \_\_\_\_\_

**IMPRESSION (Please sign and date below)**

The above named individual has been examined today. The patient has been found to be in good health, without evidence of infectious disease. There is no contraindication to general anesthesia or surgery as scheduled.

Signature: \_\_\_\_\_

Print/Stamp Name: \_\_\_\_\_

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

**Fax to (215) 405-2528 or email to redlion@cavitybusters.com**

Patient Label
Revised 3.26

**IMPORTANT REMINDERS FOR DAY OF PROCEDURE**

**NO EATING AFTER MIDNIGHT  
NO CANDY, JUICE, OR MILK**



**MAY HAVE WATER ONLY UNTIL  
TWO HOURS BEFORE ARRIVAL**

**NO SCHOOL OR DAY CARE  
ON DAY OF PROCEDURE**



**NO MEDICINE OR VITAMINS ON  
DAY OF PROCEDURE, UNLESS  
OTHERWISE DIRECTED**



**FOR YOUR CHILD'S SAFETY - YOUR PROCEDURE WILL BE  
CANCELLED IF THESE GUIDELINES ARE NOT FOLLOWED**

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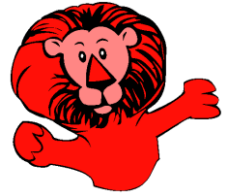
## PRE-OP INSTRUCTIONS

1. **ABSOLUTELY NO FOOD AFTER MIDNIGHT THE NIGHT BEFORE SURGERY.**
  - NOTHING to eat after midnight the night before surgery, INCLUDING gum, hard candy or cough drops. Alternative instructions MAY be provided for children. The nurse will alert you to these during the pre-operative phone call (see # 3 below).
  - Do not send your child to school or daycare the morning of their procedure since it is impossible to guarantee that they will not eat or drink anything.
2. The patient may brush their teeth, but do NOT swallow any liquid.
3. A Surgicenter nurse will call you 2 business days before the procedure to give you further instructions and to tell you whether the patient should take any medications the morning of surgery.
4. Please contact the Surgicenter if your child becomes sick within the 2 weeks prior to surgery with any symptoms of a **SEVERE** upper respiratory infection (fever, sore throat, hoarseness, bad cough, wheezing).
5. **AN ADULT MUST ESCORT THE PATIENT AT THE TIME OF DISCHARGE AND HAVE A RESPONSIBLE ADULT AT HOME WITH THEM FOR 24 HOURS AFTER THE PROCEDURE.**
6. You must have a ride home. You cannot take public transportation home after anesthesia.
7. The patient should wear loose, comfortable clothing (short sleeve shirts are preferred).
8. The patient should not wear contact lenses; they should wear glasses. NO eye or face makeup.
9. The patient should leave all jewelry and valuables at home: The Surgicenter is unable to store them. **THE SURGICENTER WILL NOT BE RESPONSIBLE FOR LOST OR STOLEN ITEMS.**
10. If you fail to follow these instructions, a potentially dangerous situation could arise and may lead to the cancellation of the procedure.
11. If you have any questions, call the Surgicenter between the hours of noon and 3 p.m. one or more days before the procedure.
12. Be aware that if the patient's condition requires additional care, arrangements will be made to transfer the patient to a local hospital.
13. To insure safety and confidentiality, we do not routinely allow family members or companions in our recovery room. One parent will be allowed to sit with pediatric patients.
14. If there are any restrictions which would impact activity or travel after the procedure, your physician or dentist will discuss with you prior to scheduling.

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## PATIENT INFORMATION PACKET

### POLICIES & PROCEDURES

**Zero Balance Facility:** We do NOT bill patients – only insurance companies. Red Lion Surgicenter will bill your medical insurance company. Any portion of your billed not covered by your insurance is your responsibility. Payment for co-pays and non-covered services are due at the time of treatment. We accept cash, check and major credit cards. We also have no interest and low interest payment plans through Care Credit. Please ask for information.

**Leaving the Surgicenter:** Please do not leave the office during your child's visit. Treatment plans sometimes change during the procedures and the doctor may need to speak with you.

**Cancellation Policy:** You must call us 48 hours in advance if you cannot make your appointment.

Please be advised that the actual dental services performed are billed to your dental insurance plan. Your medical insurance plan is billed for use of the facility, nursing, medical supplies and anesthesia services only. Medical insurance companies do require a complete list of procedures performed, however they will not cover or make payments on any dental procedures.

**Predeterminations:** These are only estimates. Your insurance company will not provide us a 100% accurate fee until the work is completed and they have received your claim form from us. We try to gather as much information as we can, but please remember that insurance is a contract between you and your insurance company.

**Guardianship Paperwork:** If you are other than the natural mother or father and have legal responsibility for the child, we require a copy of the document appointing you legally responsible. Only the legally responsible party can sign the Consent for Anesthesia and Conditions of Admission on the day of surgery.

### CONSENT OF FINANCIAL RESPONSIBILITY

Even though we will check with your insurance company to determine if you need to have a prior authorization, ultimately you are responsible for any specific policies or penalties required by your insurance company to see if your plan has any conditions you need to know about.

In the event the service is not covered by your insurance company, you are financially responsible for the services provided.

If your insurance company does not pay the entire bill, we will send you a statement to notify you of any remaining unpaid balances. Whatever your insurance company does not pay is your responsibility.

Please remember that due to age, behavior, or Special Needs issues, your child's dental work may be significantly more involved than originally thought once x-rays are reviewed and a thorough treatment plan is completed.

Major credit cards, cash, checks, and Care Credit are accepted methods of payment for your portion of the bill. If you have problems with your portion of your bill, please let us know.

## **ANESTHESIA BILLING INFORMATION**

Associates in Anesthesia, Inc. is pleased to be the anesthesia provider in partnership with Red Lion Surgicenter.

Patients Covered by all Pennsylvania Medicaid Plans services are covered 100%.

Patients with Private Insurance:

Call your insurance company to see if your individual plan covers “anesthesia services for dental surgery at Red Lion Surgicenter”. If your carrier does not cover anesthesia services for dental procedures, we recommend you contact your employer’s Human Resources department to verify this information. If your insurance does not cover anesthesia services for dental procedures, please see the fee schedule below.

\$550.00 for the first hour or any portion of that hour, \$125.00 for each additional 15 minutes or portion thereof. For example: 1 hour and 30 minutes procedure would be: \$550 + \$250 = \$800

Our anesthesia fee is in addition to any other fees for your procedure and is an estimate only. If the actual anesthesia time is over or under the estimated time we will bill or refund you the difference. (\$125.00 for every 15 minutes).

A representative from Associates in Anesthesia will contact you prior to your procedure with their estimated charge. Payment must be made prior to your service. AIA accepts the following credit cards: Visa, MasterCard, Discover, American Express and Care Credit. Personal checks and Money Orders are also accepted. If paying by check or money order, please make it payable to: Associates in Anesthesia, Inc.

If you have any questions, please feel free to call AIA’s billing office at 610-874-6448, extension 107.

## **AMENITIES INFORMATION**

The Red Lion Surgicenter strives to provide quality care for you and your family in a comfortable, safe environment. For your convenience we have the following amenities available: ♦Free Wi-fi ♦ Television ♦ Water cooler ♦ Keurig coffee machine (in waiting room) ♦ Snack Vending machines (just ask an employee) ♦ Beverage Vending machines (just ask an employee) ♦ Off-street parking ♦ Wheelchair access ♦ Video games.

## **MISSED APPOINTMENT POLICY**

We’re pleased your child is scheduled for dental treatment at Red Lion Surgicenter — an important step toward a healthy smile.

Surgicenter appointments require coordination among our administrative team, surgical staff, insurance coordinators, dentists, and assistants. Significant time and resources are dedicated to preparing for your child’s procedure, and we appreciate your partnership in making the day a success.

Once scheduled, we ask that families arrive on time and follow all pre-operative instructions. If you need to cancel or reschedule, please provide **at least 48 hours’ notice** (excluding weekends). Weekend cancellations may be left on our answering machine. Patients who do not arrive for their appointment without proper notice will be moved to the bottom of the waiting list.

We understand that illness and unexpected issues can arise. If your child is sick and 48-hour notice is not possible, a doctor’s note may be provided to avoid being placed at the bottom of the waiting list.

Thank you for your cooperation and commitment. Please call with any questions.

## **ADVANCED DIRECTIVE POLICY**

Federal regulations require that we inform you in advance of the date of your procedure our policies regarding Advance Directives:

Red Lion Surgicenter is a “Full Code” facility. By this we mean that every medical intervention available to us will be used to insure that your procedure has a successful outcome including any and all available resuscitative measures in the case of a medical emergency.

We request that all patients who have executed an “Advance Directive” inform us of this fact as soon as possible. Upon notification we will explain our “Full Code” policy in more depth and gain a better understanding of the directives that you have stipulated in the event of a medical emergency.

Patients who have executed an “Advance Directive” which include directives that conflict with Red Lion’s “Full Code” policy may at anytime decide to cancel their procedure and have it rescheduled at a facility of their choice.

## **DISCLOSURE OF PHYSICIAN OWNERSHIP**

- Joshua A. Bresler DMD, Jason M. Bresler DMD, and Rachel Bresler DMD are owners of Red Lion Surgicenter.
- You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Red Lion Surgicenter. You will not be treated differently by your physician if you choose to obtain health care services at a facility other than Red Lion Surgicenter.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Red Lion Surgicenter. We welcome you as a patient and value our relationship with you.

## **PATIENTS’ RIGHTS**

1. A patient has the right to respectful care given by competent personnel.
2. A patient has the right, upon request, to be given the name of his attending practitioner, the names of all other practitioners directly participating in his care, and the names and functions of other health care personnel having direct contact with the patient.
3. A patient has the right, upon request, to change their provider if other qualified professional are available.
4. A patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination and treatment are considered confidential and should be conducted discreetly.
5. A patient has the right to have records pertaining to his medical care treated as confidential except as otherwise provided by law or third party contractual arrangements. Except when required by law, patients are given the opportunity to approve or refuse release of their records.
6. A patient has the right to know what ASF rules and regulations apply to his conduct as a patient.
7. A patient has the right to expect emergency procedures to be implemented without unnecessary delay. A patient also has the right to be informed about Center provisions for emergency and after hours care. A patient has the right to be informed of the Center’s policy with regard to advance directives.
8. A patient has the right to good quality care and high professional standards that are continually maintained and reviewed. A patient has the right to receive information regarding the Center’s credentialing policies.
9. A patient has the right to full information, in layman’s terms, concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his behalf to the patient’s next of kin or other appropriate person.
10. Except for emergencies, the practitioner shall obtain the necessary informed consent prior to the start of a procedure. Informed consent is defined in section 103 of the Health Care Services Malpractice Act (40 P.S. §1301.103).
11. A patient or, in the event the patient is unable to give informed consent, a legally responsible party, has the right to be advised when a practitioner is considering the patient as part of a medical care research program or donor program, and the patient or legally responsible party must give informed consent prior to actual participation in such program. A patient or legally responsible party may, at any time, refuse to continue in any such program to which he has previously given informed consent.

12. A patient has the right to refuse drugs, treatment, or procedures offered by the Center, to the extent permitted by statute the practitioner will inform the patient of the medical consequences of the patient's refusal of drugs, treatment or procedures.
13. A patient has the right to medical and nursing services without discrimination based upon age, race, color, religion, sex, gender, sexual orientation, national origin, handicap, disability or source of payment.
14. A patient who does not speak English shall have access, where possible, to an interpreter.
15. The Center shall provide the patient, or patient designee, upon request, access to the information contained in his medical records, unless the attending practitioner for medical reasons specifically restricts access.
16. A patient has the right to expect good management techniques to be implemented within the Center considering the effective use of time of the patient and to avoid the personal discomfort of the patient.
17. When medically advisable, a patient may be transferred to another facility. He or his next of kin or other legally responsible representative will be provided with complete information and an explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred shall be notified prior to the patient's transfer.
18. A patient has the right to examine and receive a detailed explanation of his bill, and to receive information on fees for services received and on Center payment policies.
19. A patient has the right to be informed of his rights at the time of admission.
20. Marketing material does not mislead patients regarding the Center's capabilities or competence.
21. A patient has the right to be informed of procedures for expressing suggestions and policies regarding grievance procedures.
22. A patient has the right to expect that the Center will provide information for continuing health care requirements following discharge and the means for meeting them.

## **PATIENTS' RESPONSIBILITIES**

Patients are expected to:

1. Provide accurate and complete information about their present complaints, past medical illnesses, hospitalizations, surgeries, medications, and other matters relating to their health.
2. Tell their health care providers whether they understand the treatment, plan of care, and what is expected of the patient.
3. Help the practitioners, nurses and other allied health personnel in their efforts to care for patients by following their instructions and medical orders.
4. Observe the no smoking policy of the Center.
5. Meet all financial obligations incurred for services provided at the Center.

It is always best to make every effort to address patient/visitor complaints internally through discussion, investigation and potential action by/among Center personnel and the patient/visitor. Therefore, in accord with Administrative policy 341, any and all patient/visitor complaints should initially be brought to the attention of Center personnel such as the Medical Director or Director of Nursing. If necessary, patients/visitors wishing to register a complaint regarding the Center with the Pennsylvania Department of Health may do so by calling 1-800-254-5164.

## **NOTICE OF PRIVACY PRACTICES**

This Notice describes how medical and dental information about you may be used and disclosed and how you can get access to this information.

The privacy of your health information is important to us.

### **Our Legal Duties**

We are required by the Health Insurance Portability and Accountability Act (HIPAA), the HIPAA Omnibus Rule, the Health Information Technology for Economic and Clinical Health Act (HITECH), 42 C.F.R. Part 2 (for certain substance use disorder records), and other applicable federal and state laws to keep your protected health information ("PHI") private. We must give you this Notice, which explains how we may use and share your information and what rights you have. We must follow the terms of this Notice while it is in effect. We may change our privacy practices and this Notice at any time, as allowed by law. Any changes will apply to all PHI that we maintain, including information created or received before the changes. If we make a significant change, we will update this Notice and make the new version

available in our offices (and on our website, if we have one). You may request a paper copy of this Notice at any time, even if you agreed to receive it electronically.

### **How We Use and Disclose Your Health Information**

We may use and disclose your health information for the following purposes without your written permission, as permitted by law.

- **Treatment** - We may use or share your information to provide, coordinate, or manage your dental care and related services. For example, we may share information with your pediatrician, another dentist, an oral surgeon, or a pharmacy involved in your care.
- **Payment** - We may use or share your information to obtain payment for services we provide. For example, we may share information with your health or dental plan to get prior authorization or to bill and collect payment.
- **Health Care Operations** - We may use or share your information for our “health care operations.” These activities help us run our practice and improve quality. Examples include:
  - Quality assessment and improvement activities.
  - Reviewing the competence and performance of our staff and providers.
  - Training of students and staff.
  - Accreditation, certification, licensing, and credentialing activities.

### **Your Authorization**

Other uses and disclosures of your information that are not described in this Notice will be made only with your written authorization. If you give us written authorization, you may revoke it in writing at any time. Revoking your authorization will not affect any use or disclosure of your information that took place before we received your revocation.

### **Special Protections for Substance Use Disorder (SUD) Records**

Some records that identify you as having or having had a substance use disorder (such as alcohol or drug use disorder), and that are created by or received from a federally assisted SUD treatment program, are protected by an additional federal law called 42 C.F.R. Part 2 (“Part 2”). When we receive or maintain SUD treatment records subject to Part 2, we generally must obtain your specific written authorization before we use or disclose those SUD records, unless Part 2 specifically allows the use or disclosure without authorization (for example, in a medical emergency, for certain audits and evaluations, or as otherwise permitted by law). A single written consent may allow the use and disclosure of SUD records for treatment, payment, and health care operations, similar to HIPAA. SUD records protected by Part 2 cannot be used or disclosed in most civil, criminal, administrative, or legislative proceedings against you unless (a) you provide written consent, or (b) a court issues an order that meets Part 2’s strict requirements. If we disclose your SUD records pursuant to your authorization or a court order, the recipient may not redisclose them unless you authorize that redisclosure or Part 2 allows it.

### **Other Uses and Disclosures Permitted or Required by Law:**

#### **Out-of-Pocket Payments**

If you pay for a service in full out of pocket, you may request that we not disclose information about that service to your health plan. We will honor this request unless a law requires us to share that information.

#### **Individuals Involved in Your Care or Payment**

With your agreement (or when you do not object), we may share relevant information with a family member, friend, or other person involved in your care or payment for your care. If you are unable to agree due to incapacity or an emergency, we may use our professional judgment to determine what is in your best interest.

We may also use or disclose information to locate or notify a family member, personal representative, or another person responsible for your care about your location, general condition, or death.

#### **Appointment Reminders and Communications**

We may use or disclose your information to contact you with appointment reminders or to communicate about treatment options and other health-related benefits or services that may be of interest to you (for example, voicemail messages, postcards, emails, text messages, or letters).

#### **Marketing and Sale of PHI**

We will not use your PHI for marketing communications or sell your PHI without your written authorization, except as permitted by law. If we contact you to raise funds for our organization, you have the right to opt out of receiving further fundraising communications.

### **HIV-Related Information (Pennsylvania)**

HIV-related information is specially protected under Pennsylvania law. We will not disclose HIV-related information about you without your specific written consent, except as the law allows or requires.

### **Abuse, Neglect, or Violence**

We may disclose your information to appropriate authorities if we reasonably believe you are a possible victim of abuse, neglect, or domestic violence or the victim of another crime, as permitted or required by law.

### **Public Health and Health Oversight**

We may disclose information for public health activities (such as disease reporting, product recalls, or preventing or controlling disease) and to health oversight agencies for activities authorized by law.

### **Legal Proceedings and Law Enforcement**

We may disclose information in response to a court or administrative order, subpoena, discovery request, or other lawful process, but only as allowed by law. For SUD records, additional Part 2 requirements apply, and most disclosures for legal proceedings require your consent or a specific Part 2 court order. We may also disclose information to law enforcement officials for certain purposes such as identifying or locating a suspect, complying with a warrant, or reporting certain injuries, as permitted by law.

### **Serious Threat to Health or Safety**

We may use or disclose information when necessary to reduce or prevent a serious threat to your health or safety or the health or safety of others, consistent with applicable law.

### **Specialized Government Functions and Inmates**

We may disclose information for certain specialized government functions, such as military or national security activities, and to correctional institutions or law enforcement officials having lawful custody of an inmate or patient, as permitted by law.

### **Breach Notification**

If a breach of unsecured PHI occurs and a risk assessment shows that your information has been compromised, we will notify you as required by law. We may also need to notify government authorities and, in some cases, the media.

### **Your Rights**

You have the following rights concerning your PHI.

**Right to See and Get Copies:** You have the right to look at or get a copy of your health information, including an electronic copy when we maintain your information electronically, with limited exceptions. You must make a written request. We may charge a reasonable, cost-based fee for copies, staff time, and postage, as allowed by law. You may also request that we send a copy directly to another person or entity you designate in writing.

**Right to an Accounting of Disclosures:** You have the right to request a list (“accounting”) of certain disclosures we have made of your health information in the six years before your request, not including disclosures for treatment, payment, health care operations, and certain other disclosures. If you request more than one accounting in a 12-month period, we may charge a reasonable, cost-based fee.

**Right to Request Restrictions:** You have the right to request additional restrictions on our use or disclosure of your information. We are not required to agree to all requested restrictions, but we must honor certain restrictions, such as those related to services you have paid for in full out of pocket.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you in a specific way (for example, at work instead of at home) or at a specific location. Your request must be in writing and tell us how or where you prefer to be contacted. We will accommodate reasonable requests.

**Right to Request an Amendment:** If you believe that information we have about you is incorrect or incomplete, you have the right to request that we amend your record. Your request must be in writing and explain why the information should be changed. We may deny your request in certain circumstances (for example, if the information was not created by us or is already accurate and complete).

**Right to a Paper Copy of This Notice:** You have the right to obtain a paper copy of this Notice at any time, even if you agreed to receive it electronically.

**How to Exercise Your Rights or Ask Questions:** To exercise any of these rights, ask questions, or get more information about our privacy practices, please contact:

Red Lion Surgicenter

Telephone: 215-676-2232

Fax: 215-676-7130

### **Complaints**

If you believe we have violated your privacy rights or you disagree with a decision we made about your PHI, you may file a complaint with us using the contact information above. You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. We will provide you with the appropriate address upon request. We will not retaliate against you for filing a complaint.