



S U R G E R Y • C E N T E R

### CMS PRIOR TO SURGERY/PROCEDURE NOTIFICATION REQUIREMENTS

**Advanced Directive:**

Under federal and state law, you or your representative have the legal right to make informed decisions regarding your care. It is our policy, regardless of the contents of any advanced directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at Newport Beach Surgery Center we will initiate resuscitation or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive or health care power of attorney.

**Exercise of rights and respect for property, person, privacy and safety.**

You have the right to:

- Exercise your rights without being subjected to discrimination or reprisal.
- Voice grievances regarding treatment of care that is (or fails to be) furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Have a legal representative exercise your rights to the extent allowed by state law whether adjudged competent or incompetent.
- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse and harassment.

It is the responsibility of Newport Beach Surgery Center to disclose that physicians have financial interest in the Center where you have been scheduled to have your procedures/surgery as stated in the Federal Register 42 CFR 416.50 Conditions for Coverage.

To obtain a list go to <http://168.143.58.73/physicianOwners.php> or contact the Center directly at (949) 631-0988.

- I or my representative have been provided with information concerning the NBSC policies on advanced directives including applicable State health and safety information.
- I or my representative have been provided with verbal notice of the patient's rights in a language and manner that the patient or the patient's representative understands.
- Physician financial interests or ownership in the ASC have been disclosed to me or my representative.

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

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

Witness: \_\_\_\_\_

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

