You are scheduled to see us for:

☐ Surgical excision with repair
☐ MOHS surgery with repair
☐ Other surgery

Date: ____________________________ Time: ____________________________ AM / PM

In order for us to better serve you it is important that we have the following items prior to your surgery date:

- Pathology report (from your biopsy) if we did not order the report.
- Patient Registration Form if you are new to our practice or it has been >1 year since your last visit.
- Health History Form (enclosed) - must have been updated within the past 30 days
- All health insurance information must be up to date
- Referral from your PCP (if you are enrolled in an HMO or if your plan requires a referral
- Completed copies of the following enclosed forms must be returned to RSC
  1. Financial Matters/Ownership Disclosure Form
  2. Patient Acknowledgment Form
  3. Health History Form
- Copy of all medications - both Prescription and Non-Prescription.

If you require a referral, make sure your PCP checks consult and treatment under “Services Required,” and marks Office and Outpatient Medical/Surgical Center under “Places of Service,” or the referral will not be valid.

You will have the procedure performed in Rockledge Surgery Center, Inc. located in the offices of The Dermatology Center at 6410 Rockledge Drive, Suite 201, Bethesda, Maryland 20817. This Nationally Accredited, Medicare-certified and State licensed surgical facility provides for high-quality outpatient surgical services.

Be advised that minors undergoing a surgical procedure must be accompanied by parent or legal guardian. If you are a legal guardian for someone undergoing a surgical procedure, please provide proof of legal guardianship to sign the consent.

If you are scheduled for Mohs surgery, enclosed is a copy of a “Patient’s Guide to MOHS Surgery”. Please review the guide as a blueprint for your treatment the day of surgery.

Prior to your surgery, if you have any medical questions call and ask for Maria Claudia Perez, surgical coordinator, or a member of the RSC surgical team.

**Bring completed paperwork with you on the day of your procedure.**

Thank you for choosing Rockledge Surgery Center for your surgical care.
You are scheduled for a surgical procedure at Rockledge Surgery Center (RSC). RSC surgery facilities provide the highest-quality outpatient surgical services available. RSC is a Medicare certified, State licensed, accredited surgical facility.

Your procedure at the RSC Facility will be performed by a Dermatology Center physician and there will be two (2) separate claims billed to your insurance carrier on your behalf as follows:

1. A claim from The Dermatology Center, PA for the services performed by your physician; and,
2. A claim from Rockledge Surgery Center covering the costs of the facility in connection with the procedure performed.

You will also receive separate charges from the pathology lab if used.

Additionally, there is a $100.00 No Show Fee and/or Cancellation fee if the procedure is cancelled 24 hours or less from date of procedure.

In advance of your procedure, you will be contacted by a representative from the RSC to discuss any copayment, coinsurance or deductibles that may be due, along with any other necessary payment arrangements.

Rockledge Surgery Center participates with Medicare, Carefirst/Blue Choice, AETNA, CIGNA and United Healthcare/OneNet. If you have other coverage, your out-of-network benefits will be billed for the facility charge. Please contact Maria Claudia Perez-Janssen, Surgery Center Coordinator, at: 301-530-8300 ext. 760 for questions. You will receive prior notification by telephone about your anticipated financial responsibility, pre-operative and post-operative instructions.

Dermatology & MedSpa, Inc. owns and operates the RSC where you are scheduled to have your surgical procedure. If you wish to discuss this ownership interest with your physician or learn about other treatment options and/or facilities, please let the RSC representative know that when they contact you, or simply call your physician at the office. Your choice of treatment options is yours and will always be respected.

If you wish to have your procedure performed with RSC, please sign below. In signing, you are also acknowledging that you have read this form, including the disclosure of ownership, and have had an opportunity to ask questions, express concerns and explore your options.

Signature-Patient or Legal Guardian       Date
HEALTH HISTORY

Name ___________________________ Occupation ___________________________

Age _____ Sex _____ Height _____ Weight _____ Ethnicity/Race ____________________

Name, Address, and Phone Number of Primary Care Physician

____________________________________________________________________________

Medications Taken/Prescription and Non-Prescription

____________________________________________________________________________

Do you have Advanced Directives? Yes ___ None ___

Do you have any drug allergies? Yes ____ None ____ List ______________________________

Do you have any allergies to latex? Yes ____ No ___

Reactions: Rash___ Hives___ Shortness of Breath ___ Other____

Do You Smoke: Yes ____ No ____ How Much ____ How Many Years? _____

Do You Drink Alcohol: Yes ____ No ____ How Much ____ Everyday _____

Do you have a personal history of skin cancer: Yes ____ No ___ Type ____________________

Do you have a family history of skin cancer: Yes ____ No ____ Type ____________________

PLEASE CIRCLE THOSE THAT APPLY

DO YOU HAVE A HISTORY OF:

Recent Cold  Diabetes  Swollen Ankles
Hayfever  Thyroid Disease  Chronic Cough
Back Pain  Asthma  Shortness of Breath
Painful Joints  Stroke  High Blood Pressure
Pneumonia  Anemia  Paralysis
Tuberculosis  Dentures  Kidney Stones
Emphysema  Loose Teeth  Liver Disease
Bronchitis  Hearing Aid  Hepatitis
Heart Attack  Ulcer  Cirrhosis
Angina  Hiatal Hernia  Jaundice
Heart Failure  Kidney Disease  COPD
Irregular Heart Beat  Bladder Trouble  Arthritis
Pacemaker  Cancer/Tumor  Fainting/Dizziness
Epilepsy/Seizures  Sickle Cell Anemia  Prolonged Bleeding
Sexually/Blood Transmitted Disease

Have you or any member of your immediate family had an unusual reaction to anesthesia?

____________________________________________________________________________

Have you had surgery before? Yes ____ No ____ If yes, please list ______________________

____________________________________________________________________________

PATIENT SIGNATURE ___________________________ DATE __________________________

REVIEWED WITH PATIENT:

Surg. Initial _______ R.N. Initial _______ Date Reviewed w/Patient ________

Surg. Initial _______ R.N. Initial _______ Date Reviewed w/Patient ________
I hereby acknowledge I have been, advised in advance of the scheduled date of my procedure, regarding the following surgery center practices and policies:

Initial ________ 1. I have received a written copy of the Patient Bill of Rights.

Initial ________ 2. I have received written information regarding the facility financial matters and ownership disclosure.

Initial ________ 3. I have received information regarding the facility Privacy and Confidentiality Policy. I was offered a written copy.

Initial ________ 4. I have received information regarding the surgery center advance directives policy. I was advised I could receive a copy of the official State advanced directives form. Additionally, I have been advised that should I have advance directives, I may bring them to the surgery center and they will be placed in my medical record. I was advised the surgery center does not recognize advanced directives.

YES ☐ NO ☐ Do you have advance directives?

YES ☐ NO ☐ Patient provided a copy of their Advance Directives

Initial ________ 5. I have been advised Dermatology & MedSpa, Inc. has ownership or financial interest in the surgery center.

Signature ___________________________ Date ___________________________

Witness ___________________________ Date ___________________________
PATIENT'S RIGHTS AND RESPONSIBILITIES

The services of the ambulatory surgery center shall be available to all individuals regardless of race, color, creed, sex, religion or national origin. All patients and their families shall be treated with respect, consideration and dignity.

All patients are encouraged to actively participate in their medical and surgical treatment plan. Patients shall be provided with all relevant information concerning their diagnosis, treatment and prognosis. When necessary or appropriate this information will be available and discussed with an appropriate patient designate or legally authorized patient representative.

Representatives from the ambulatory surgery center will ensure the following information has been made available to each patient, both verbally and in writing, in a language and manner that the patient or the patient’s representative understands:

1. Rockledge Surgery Center, Inc. provides dermatologic and plastic/reconstructive surgical and diagnostic services. Patients shall be advised should the facility fail to maintain malpractice insurance.

2. The provisions regarding the normal hours of operation of the ambulatory surgery facility and specific directions to address after hours emergency concerns or issues which may arise. The patient, or the patient's representative, shall receive both written and oral discharge instructions providing guidance and appropriate telephone numbers to accomplish after hours contact.

3. The patient shall receive clear and concise information regarding the procedures planned, the anticipated outcome or results, and the consequences of refusing treatment or not complying with the established treatment plan. There shall be a written, signed and witnessed surgical consent obtained prior to each surgical or diagnostic procedure performed in the facility.

4. The ambulatory surgery center shall not provide treatment to unemancipated minors not accompanied by an adult. The minor’s parent, legal guardian or properly designated and pre-authorized representative must be present at the facility prior to an unemancipated minor receiving treatment in the facility. A pre-authorized patient representative must be designated in writing by the minor’s parent or legal guardian prior to the date of surgery.

5. The patient shall be advised if the proposed treatment is experimental research. The patient shall be provided full and complete explanation regarding the procedure, the prognosis for success and alternatives. The patient shall have the right to refuse experimental research procedures, as well as any course of treatment with which they do not agree or approve. Patients may change their primary or specialty physician.

6. Each patient shall be informed regarding the fees associated with the use of the facility prior to the date of their procedure. The patient shall be advised of the ambulatory surgery center's policy regarding the processing of insurance forms, the payment of patient co-pays and deductibles and the policy concerning balance billing for services rendered. Patients shall be provided with appropriate privacy throughout the delivery of healthcare services.

7. All information provided to the patient concerning the ambulatory surgery center shall accurately reflect the facilities competence, capabilities, licensure, certification, and accreditation.

8. I have been advised that Dermatology & MedSpa, Inc. have a financial interest or ownership of Rockledge Surgery Center, Inc.
9. Patients, or the patient’s representative, will be advised in advance of the date of the procedure with information concerning the facility policies on advanced directives, including a description of applicable State health and safety laws, and, if requested, a copy of the official State advance directive forms. Patients may have advanced directives regarding their healthcare. Surgical center staff will inquire as to whether a patient has advanced directives and discuss the impact of such Advanced Directives on the patient’s healthcare services to be provided by the surgery center. In the event of an emergent medical event occurring during your surgical procedure, you will be stabilized and 911 will be called to transport you to the closest hospital. **The surgery center does not recognize Advanced Directives.**

10. The surgery center has a grievance policy which provides a mechanism for the filing of grievances or complaints with the facility management. All alleged grievances or complaints will be addressed to Maria-Claudia Perez, Surgical Coordinator within forty-eight hours. Any grievance or complaint relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, will be documented. The individual filing the alleged grievance or complaint will receive a written response within one week. Substantiated allegations will be reported to the State authority or the local authority, or both. All grievances made by a patient or the patient’s representative regarding treatment or care that is (or fails to be) furnished will be immediately investigated and documented. The surgery center will document how the grievance was addressed, as well as, provide the patient with written notice of its decision. The decision will contain the name of the surgery center contact person, the steps taken to investigate the grievance, the results of the grievance process and the date the grievance process was completed.

Grievances or complaints should be directed to Maria-Claudia Perez, Surgical Coordinator in writing or by telephone at 301-530-8300.

Grievances or complaints regarding the surgery center may also be directed to the Maryland State Department of Health and Mental Hygiene, Office of Health Care Quality, Program Manager, Ambulatory Care Services, Bland Bryant Building, 55 Wade Avenue, Baltimore, Maryland 21228 or at 800-492-6005 or 410-402-8040 by email at [www.dhmh.maryland.gov/ohcq](http://www.dhmh.maryland.gov/ohcq) or by completing a written Compliant Report Form available from the ambulatory surgery center management.


11. The patient has the right to exercise his or her rights without being subjected to discrimination or reprisal; to voice grievances regarding treatment or care that is (or fails to be) furnished; to be fully informed about a treatment or procedure and the expected outcome before it is performed.

12. 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.

13. The patient has the right to personal privacy, receiving care in a safe manner, and being free from all forms of abuse or harassment.

14. The surgery center will comply with the Department’s rules for the privacy and security of individually identifiable health information, as specified at 45 CFR, parts 160 and 164.

15. Information regarding provider credentialing will be maintained by the surgery center and shall be available to patient’s upon request.
PATIENT RESPONSIBILITIES

Arrive on time, prepared as directed, for your appointment. If an appointment needs to be changed or canceled, provide the surgery center as much notice as possible.

The patient shall provide accurate and up to date information concerning their health history, medications and insurance. Any changes to this information must be immediately conveyed to the surgery center staff.

If the patient is a minor, the parent or guardian is to remain in the ambulatory surgery center while the patient is undergoing treatment. The parent or guardian shall provide care and guidance to the minor patient concerning post-op and follow-up care.

The patient shall adhere to their physicians ‘directions regarding their health care treatment plan.

The patient is encouraged to ask their physician or other health care provider questions regarding their proposed course of treatment should they not clearly understand what is being recommended.

Patients are encouraged to obtain a second opinion, from another qualified physician or health care provider, should they be unsure of the proposed course of treatment.

Patients are expected to pay co-pays, deductibles and the balance of their medical bill according to the pre-arranged schedule of payment. If payment cannot be made, the Surgical Coordinator must be contacted prior to the due date of the payment.

Ask questions, whenever you are unsure of what is being proposed.
WHAT IS AN ADVANCE DIRECTIVE?

In the event you become unable to tell your physician and family how you want to be treated, federal and state laws have provided ways for you to make your wishes regarding health care services known. The Federal Patient Self-Determination Act and the Maryland Health Care Decisions Act state that each competent adult has the right to prepare a written “Advance Directive” regarding health care decisions. An Advance Directive enables you to indicate your wishes regarding health care treatment and/or designate a health care agent to make decisions about your health care.

Through an Advance Directive you can let health care providers know what treatments you want to have or not have, including life-sustaining procedures and the circumstances under which you wish these procedures to be withheld or withdrawn. (Sometimes these types of decisions regarding health care are in a document called a Living Will.) An Advance Directive helps protect your rights to make medical choices that can affect your life. The stress on your family during a difficult time can be considerably reduced because your family will be relieved of the responsibility of trying to decide what your wishes would be. Your family and physician will have clear guidelines concerning your wishes for your care.

You may also designate a health care agent to carry out your wishes. Designation of health care agent allows you to name a person who will make health care treatment decisions on your behalf should you become incapacitated. (Sometimes the individual chosen to make such decisions is appointed by a Durable Power of Attorney of Health Care.) A health care agent must be named by you before you become incapacitated.

ARE ADVANCE DIRECTIVES HONORED AT ROCKLEDGE SURGERY CENTER?

Please inform your physician and the Center about any Advance Directive you may have. Advance Directives are not honored at Rockledge Surgery Center, but that information is an important part of your medical record and will accompany you in the event of a transfer from the Center to Another Facility. Should a life-threatening emergency arise during anesthesia or surgery at the Center, we will undertake resuscitation. You will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by your physician and family.

If you (or your representative) do not wish resuscitation under such circumstances, Center staff will work with you to identify an alternative facility for your procedure that will comply with your wishes.

For your ease of reference, and in accordance with federal and state requirements, you will find attached to this correspondence an “Advance Directives Information Sheet” that provides general information on Advance Directives in the state of Maryland. Additional information, developed by the State of Maryland of the Attorney General, is available on the web at: www.oag.state.md.us/Healthpol/adirective.pdf. Included on the website are forms that may be completed electronically and then printed to be signed and witnessed. If you do not have access to a computer but wish additional information on an Advance Directive, including forms that can be used to prepare an Advance Directive, please ask the Center’s staff for a copy of the “A Guide to Maryland Law on Health Decisions.”

MIEMSS Form
As noted above, in accordance with Maryland law, if you come to the Center with a valid Maryland Emergency Medical Service (EMS) Do Not Resuscitate (DNR) and Medical Care Order form, or valid evidence of the DNR order in a bracelet or necklace form, your DNR will be copied or noted in your medical record but WILL NOT be honored by the Center.
Your Information.  
Your Rights.  
Our Responsibilities.

You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we’ve shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ See page 2 for more information on these rights and how to exercise them

You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ See page 3 for more information on these choices and how to exercise them

We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers’ compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ See pages 3 and 4 for more information on these uses and disclosures
### Your Rights

**When it comes to your health information, you have certain rights.**

This section explains your rights and some of our responsibilities to help you.

<table>
<thead>
<tr>
<th>Right</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Get an electronic or paper copy of your medical record</strong></td>
<td>You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.</td>
</tr>
<tr>
<td><strong>Ask us to correct your medical record</strong></td>
<td>You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.</td>
</tr>
<tr>
<td><strong>Request confidential communications</strong></td>
<td>You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.</td>
</tr>
<tr>
<td><strong>Ask us to limit what we use or share</strong></td>
<td>You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.</td>
</tr>
<tr>
<td><strong>Get a list of those with whom we’ve shared information</strong></td>
<td>You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.</td>
</tr>
<tr>
<td><strong>Get a copy of this privacy notice</strong></td>
<td>You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.</td>
</tr>
<tr>
<td><strong>Choose someone to act for you</strong></td>
<td>If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.</td>
</tr>
<tr>
<td><strong>File a complaint if you feel your rights are violated</strong></td>
<td>You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <a href="http://www.hhs.gov/ocr/privacy/hipaa/complaints/">www.hhs.gov/ocr/privacy/hipaa/complaints/</a>. We will not retaliate against you for filing a complaint.</td>
</tr>
</tbody>
</table>
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

**Treat you**

- We can use your health information and share it with other professionals who are treating you.
  
  *Example*: A doctor treating you for an injury asks another doctor about your overall health condition.

**Run our organization**

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  
  *Example*: We use health information about you to manage your treatment and services.

**Bill for your services**

- We can use and share your health information to bill and get payment from health plans or other entities.
  
  *Example*: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

**Help with public health and safety issues**

- We can share health information about you for certain situations such as:
  
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone’s health or safety

*continued on next page*
Do research  · We can use or share your information for health research.

Comply with the law  · We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests  · We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director  · We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests  · We can use or share health information about you:
  • For workers’ compensation claims
  • For law enforcement purposes or with a law enforcement official
  • With health oversight agencies for activities authorized by law
  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions  · We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Note: We do not create or manage a hospital directory at The Dermatology Center.
We do not create or maintain psychotherapy notes at The Dermatology Center.
We will not contact you concerning fund-raising at the Dermatology Center.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.
  We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
  We must follow the duties and privacy practices described in this notice and give you a copy of it.
  We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:  [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice is effective September 23, 2013

This Notice of Privacy Practices applies to the following organizations.
This notice applies to The Dermatology Center, PA and Rockledge Surgery Center, Inc.

Privacy Officer: Kelly Valente, General Counsel, 980-233-3220, kvalente@sonamedspa.com