SCC
Surgical Center of Connecticut

Surgical Center of Connecticut
4920 Main Street
Bridgeport CT 06606

Phone: (203) 371-2986

GENERAL PRE-OPERATIVE INSTRUCTIONS

- **THE SURGICAL CENTER OF CONNECTICUT IS LOCATED AT 4920 MAIN STREET, BRIDGEPORT CT, 2ND FLOOR. THIS IS AT THE CORNER OF MAIN STREET AND OLD TOWN ROAD. YOU WILL FIND PARKING IS IN THE REAR OF THE BUILDING WITH ACCESS FROM OLD TOWN ROAD.**

- **YOU WILL RECEIVE A PHONE CALL FROM THE NURSING STAFF A FEW DAYS BEFORE YOUR PROCEDURE TO COLLECT YOUR HEALTH HISTORY AND PROVIDE YOU WITH INSTRUCTIONS.**

- **PLEASE CALL THE CENTER AFTER 1PM THE DAY BEFORE YOUR PROCEDURE AT 203-371-2986 TO CONFIRM YOUR ARRIVAL THE FOLLOWING DAY. PLEASE BE AWARE THAT THE CENTER WILL CLOSE AT 5PM**

- **PLEASE FOLLOW ALL PRE-OP INSTRUCTIONS GIVEN TO YOU BY YOUR PHYSICIAN AND/OR THE CENTER. IF YOU HAVE ANY QUESTIONS ON HOW TO PROPERLY PREPARE FOR SURGERY, PLEASE CALL US AT 203-371-2986 OR CALL YOUR SURGEON'S OFFICE DIRECTLY.**

- **YOU MUST HAVE AN ESCORT WHO WILL DRIVE YOU HOME AFTER YOUR PROCEDURE AND TO STAY WITH YOU FOR 24 HOURS AFTER YOUR PROCEDURE.**

- **PLEASE BRING THE FOLLOWING TO YOUR SURGICAL APPOINTMENT:**
  - **-A FORM OF IDENTIFICATION, E.G. DRIVER'S LICENSE**
  - **-INSURANCE CARD**
  - **-ANY EXPECTED CO-PAYS OR DEDUCTIBLES**

- **PLEASE TAKE A MOMENT TO FILL OUT YOUR PRE-OPERATIVE QUESTIONAIRE ONLINE AT WWW.SIMPLEADMIT.COM UNDER THE "PATIENT START HERE" SECTION. USE THE PASSWORD "SCC914NEW" TO BEGIN YOUR SURVEY.**

- **PLEASE REVIEW THE ATTACHED DOCUMENTS PRIOR TO YOUR APPOINTMENT. THEY CONTAIN INFORMATION THAT WE ARE REQUIRED TO PROVIDE YOU AND WILL ASK FOR YOUR SIGNATURE WHEN YOU ARRIVE FOR YOUR APPOINTMENT.**

******PLEASE DO NOT WEAR JEWELRY (INCLUDING WATCHES), CONTACT LENSES, NAIL POLISH, AND DO NOT BRING ANY VALUABLES WITH YOU.**

PATIENT RIGHTS

- Patients are treated with respect, consideration and dignity.
- Patients have the right to be free from abuse and harassment while at the facility.
- Patients are provided privacy.
- Patient disclosures and records are treated confidentially and patients are given the opportunity to approve or refuse their release, except when such release is required by law.
- Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis. Should it be medically inadvisable to give such information to a patient, the information will be provided to a person designated by the patient or to a legally authorized person.
- Patients are given the opportunity to participate in decisions involving their health care except when such participation is contraindicated for medical reasons.
- Patients have the right to know the services available to them at the facility.
- Patients have the right to be informed of provisions for after-hour and emergency care, if needed.
- Patients have the right to know the facility fee for services.
- Patients have the right to be informed of patient conduct and responsibilities.
- Patients have the right to refuse to participate in experimental research.
- Patients have the right to know the credentials of health care professionals providing their care.
- Patients have the right to change their provider if other qualified providers are available.
- Patients may offer suggestions, voice complaints, and/or grievances regarding their care and/or services provided per state and federal regulations.

PATIENT RESPONSIBILITIES

- Patients must provide complete and accurate information to the best of his/her ability regarding health status: medications taken, including over-the-counter products and dietary supplements; and any known allergies or sensitivities.
- Patients are expected to follow the treatment plan as prescribed by his/her provider.
- Patients must provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours following the procedure if so required by his/her provider.
- Patients are to cooperate with facility personnel and ask questions if directions and procedures are not understood.

- Patients are expected to accept personal financial responsibility for any charges not covered by his/her insurance plans. Patients who receive direct payment from their insurances are expected to submit that payment to us within 10 days of receipt of such payment.
- Patients must be respectful of all health care providers and ancillary staff as well as other patients.

ADVANCED DIRECTIVES

It is the policy of the Surgical Center of Connecticut to **NOT** honor "Do Not Resuscitate" (DNR) Directives while you are at our facility for your procedure. Regardless, if you have an Advanced Directive, please provide us with a copy so that we may determine if we can follow any other portions and to add it to your facility record. If you do not have an existing Advanced Directive and would like information to this end, please let us know. We would be happy to provide you with the necessary forms and facts regarding your Connecticut Healthcare Proxy and Living Will.

KNOWLEDGE OF ESCORT AND AVAILABLE ADULT

I am aware that the Surgical Center of Connecticut requires the following:

1. I can **NOT** drive myself home after my procedure.
2. I must have an escort present at the Center, after the procedure, who will drive me home.
3. I should have a responsible adult available for 24 hours after the procedure.

I understand that it is my responsibility to make these arrangements before arriving at the Center for my procedure. I understand that if these arrangements are not made prior to my arrival my procedure will be canceled.

PERMISSION FOR LEAVING MESSAGES ON VOICEMAIL/ANSWERING MACHINE

I give permission to the personnel of the Surgical Center of Connecticut to leave messages on the voicemail/answering machine of the telephone number(s) I have given to my surgeon as my contact number(s). I understand that this information may include (but is not limited to) pre-operative instructions for my procedure and a follow-up call post-operatively regarding my condition.

*The signature of the patient must be obtained unless the patient is an un-emancipated minor under the age of 18 or is otherwise incapable of signing.

PHYSICIAN OWNERSHIP

The following physicians and entities have ownership in this facility:

Charles Adelmann, MD
Rahul Anand, MD
Robert Brady, MD
David Brown, MD
Gerald Cambria, MD
Neil Floch, MD
Craig Floch, MD
A. Gregory Geiger, MD
Jeremy Kaufman, MD
Sean Kelly, MD
Ignatius Komninakas, MD
Kenneth Lipow, MD
Edward Paraiso, MD
Arthur Pinto, MD
Thomas Rago, MD
Gary Richo, MD, Ph.D
Daniel Stupak, MD
Alfred Sofer, MD
Scott Waller, MD
Robert Weinstein, MD
Gary Zimmerman, MD

Merritt Healthcare Holdings

COMPLAINTS

You may contact the following for concerns or complaints related to your experience at the surgery center:

Administrator
Surgical Center of Connecticut
(203)371-2986
cwallace@ctsurgery.com

State of Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
(860)509-7400

Office of the Medicare Beneficiary Ombudsman
www.cms.hhs.gov/center/ombudsman.asp

FINANCIAL AGREEMENT

This notice serves to inform you that after your procedure today, the Center will bill your Insurance Company for services rendered by the facility.

Insurance companies handle claims processing in different ways. Some send payment for services, on the patient's behalf, directly to the Center, while others send payment directly to the patient.

If you receive a payment from your Insurance Company, please call the Center immediately at (203)371-2986. We will ask that you endorse the check over to The Surgical Center of Connecticut, and mail us the payment along with a copy of the Explanation of Benefits.

I, the patient, acknowledge that:

- My Insurance Company might send me payment for services rendered by the Facility in relation to my procedure today
- The Surgical Center of Connecticut retains the right to pursue by legal means any payment withheld by the patient

I, the patient, consent that if I received a check from my Insurance Company, I will:

- Call the Center immediately at (203)371-2986
- Endorse the check over to the Surgical Center of Connecticut
- Mail the check along with a copy of the Explanation of Benefits, immediately

Date of Procedure:_____

FINANCIAL AGREEMENT: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the Center may disclose portions of my financial and/or medical records to any person or entity who may be liable for all to any portion of the Center's chargers, including but not limited to insurance companies, health care service plans, or worker's compensation carrier(s) as well as to those individuals the Governing Body may deem appropriate to review the medical record for purpose of medical quality assurance/improvement and peer review. Whether signing as the patient of his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay the Center for all such services, at the Center's regular rates and terms, should my insurance company deny payment. I shall also be responsible for any deductible or co-pay owed at the time of service. Should this account be referred for collection to any attorney or collection agency. I shall pay all attorney's fees and collection expenses in connection therewith, if the patient's account is delinquent. I shall be responsible for paying the Center interest on the full outstanding balance at the maximum rate allowed by law.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY – By signing below, the patient/responsible adult hereby agrees to irrevocably assign all medical and/or surgical benefits, to include major medical benefits to which the patients is entitled, including Medicare, Medicaid, Champus, and all other government sponsored programs, private insurance and any other health plans to Surgical Center of Connecticut, LLC (Center) and all their providers including but not limited to laboratories, and clinical care workers. The patient/responsible adult understands that he/she may cancel in writing at any time this request for payment to Center. Medicare will only pay for services that are determined to be "Reasonable and Necessary" under section 1882(a) of Medicare law. **Furthermore, the patient/responsible adult understands that he/she is financially responsible for all services rendered.**

NOTE: Please read the above agreement carefully and make sure that you understand all terms and conditions before signing below. ***If you do not understand, please review contents with staff prior to signing.***

_____ _____

Patient/Responsible Adult Signature Date

_____ _____

Patient/Responsible Adult – Print Name Relationship to patient (if signed by person other than patient)

_____ _____

Interpreter (If required) Signature Date

Fill out this section ONLY if you *accept financial responsibility for the patient for who you have NO legal responsibility.* I, the undersigned person, hereby certify that I have accepted *total financial responsibility* for the above patient, for the care/treatments rendered to the patient by the Center and all their providers including. but not limited to: laboratories, and clinical care workers. I understand that I do not currently have any legal responsibility to provide financial support for this patient. I also understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatment/services provided to the patient by the Center. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers. ***Please fill in all sections below and sign where indicated.***

Name: Last_____ First_____ Middle Initial ___ Social Security Number_____-_____-_____

Relationship to patient:_____ Home phone number (_____)_____ Date of Birth _____

Address: _____ City:_____ State: _____ Zip code:_____

Driver's License OR Other photo ID #:_____ Type of ID:_____ State Issued:_____

Occupation:_____ Employer:_____ Business Phone Number(____)_____

Signature of Responsible Party:_____ Date:_____

Interpreter (if required): Print name:_____ Signature:_____ Date:_____

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To Our Patients:

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 2013 and we are required to abide by the terms of the *Notice of Privacy Practices* currently in effect. We reserve the right to change the terms of our *Notice of Privacy Practices* and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised *Notice of Privacy Practices* from this office.

You may have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us at the above address for more information regarding this notice.

For more information about HIPAA or to file a complaint:

Office for Civil Rights
Department of Health & Human Services
Attn: Patient Safety Act
200 Independence Avenue, S.W., Rm. 509F
Washington, DC 20201
(202) 619-0403
TDD 1-800-537-7697
FAX: (202) 619-3818

Thank you!