SPECTRA EYE INSTITUTE
9849 W. THUNDERBIRD
SUN CITY, ARIZONA 85351
(623) 583-2020

PACKET ACKNOWLEDGMENT

Welcome! You have been scheduled to have your surgery performed at Spectra Eye Institute.

Attached is a packet of information that will need your attention. Please take a moment to read, understand, complete and sign these forms prior to your surgical visit with us.

- Advance Directives for Health Care Acknowledgment
- Anesthesia Billing Information
- Grievance Procedure
- Health and History Questionnaire
- Notice of Direct Interest
- Notice of Privacy Practices (HIPAA)
- Patient Rights and Responsibilities
- Policy on Advance Directives
- Tuberculosis Questionnaire

I acknowledge that I am in receipt of the above listed forms prior to my surgery and I understand that it is my responsibility to read, understand, complete, sign and return the attached on my surgical day.

_____ _____

Patient Printed Name Date

_____

Patient Signature

Welcome to . . . .

Spectra Eye Institute, LLC

Advanced Eye Care through Advanced Technology

Spectra Eye Institute is a private outpatient surgical center dedicated to total eye care with a personal touch. Our **AAAHC accredited** and Medicare certified facility is equipped with state-of-the-art equipment to provide comprehensive ambulatory ophthalmic surgery services, including laser treatment.

IMPORTANT INFORMATION

Date of Surgery: _____

Date of Laser: _____

Check-In Time: _____

****PATIENT MUST PRESENT WITH PHOTO ID AND INSURANCE CARDS****

SPECTRA EYE INSTITUTE, LLC
9849 W. Thunderbird Blvd.
Sun City, Arizona 85351
623-583-2020

You will be given an arrival time from your physician's office. Please check in at the reception desk upon arrival. To make your stay more comfortable, please:

1. Do not eat or drink anything after midnight the night before your surgery. Your usual medication may be taken with a sip of water unless otherwise specified.
2. Bring the completed health history questionnaire. It is especially important to list all of your medications and the daily dosages.
3. **Bring your Medicare and/or other insurance cards.**
4. **Be prepared to pay your deductible, copayment and/or coinsurance.**
5. **Bring a photo ID that includes your current address.**
6. **Bring a copy of your Living Will and/or Medical Power of Attorney, if you have one.**
7. Leave all valuables and jewelry at home.
8. Wear loose-fitting clothing. We suggest you dress in layers as temperatures in the facility fluctuate.
9. Shower the night before or the morning of surgery. Avoid using facial or eye makeup on the day of your surgery.
10. Bring sunglasses.
11. Leave your dentures and hearing aids in place. You may be asked to remove your hearing aid if it is on the operative side.
12. Arrange for transportation home. A responsible adult will need to drive you home. Please tell this individual to be prepared to wait approximately 2-4 hours. **Please limit this to only one individual as we have limited space in our waiting area.** For your safety and comfort, we ask that you plan to have a responsible adult remain with you for several hours after your discharge.
13. **No cell phone use within the facility.**

Insurance

We will be happy to assist you in filing the insurance claim for your surgery. In order to do this, we will need copies of your insurance cards.

Medicare Patients: We are an approved Medicare facility. Therefore, we will bill Medicare according to their allowable rates. As a Medicare Part B participant, you are only responsible for the annual deductible, the 20% of the charges, known as "co-insurance", and any non-covered services. A Medicare supplement insurance policy may cover these charges.

Contracted Insurances: We are contracted with many major insurance plans. If you are covered under any of the plans, we will bill your insurance under the contracted guidelines. If your coverage indicates a copay, deductible or any portion for you to pay, you will be expected to pay that amount on the day of service.

Private Insurance Patients: If we have a contract with your insurance carrier, we will file the claim for you. Since we have no control over your policy limits, filing of your insurance claim does not relieve you of responsibility for the full charges.

Self-Pay Patients: If you do not have health insurance coverage, or if your insurance company will not cover your services at Spectra Eye Institute, payment for your surgery will be expected at the time of admission, unless prior arrangements have been made with our facility.

We accept many forms of payment: cash, check, money order, debit card, VISA, Mastercard and Discover.

Please come prepared to pay your deductible, co-pay and/or co-insurance at the time of surgery.

If you have any questions regarding driving directions to our facility, please reference the map below or feel free to call us at 623-583-2020.

ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

June 15, 2016

Dear Patients of Spectra Eye Institute

All of us at Spectra Eye Institute, LLC are pleased to announce that we have recently been accredited for another three years by the Accreditation Association for Ambulatory Health Care (AAAHC).

This is an important milestone in the continuing growth and success of our health care organization. Pursuing accreditation shows our commitment to providing the highest levels of quality care to our patients, and the same high level of quality in our business practices. Achieving accreditation by AAAHC is proof that we have met the rigorous standards of a nationally-recognized third party.

We are proud to have met the challenge of accreditation, and intend to consistently uphold the principles of quality improvement in patient care in the future.

If we can answer any further questions, please contact us at 623-583-2020.

Sincerely,

Daniel J. Briceland, M.D.
Medical Director

Spectra Eye Institute, LLC
Notice of Privacy Practices

EFFECTIVE DATE: September 23, 2013

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

The facility provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).We understand that your medical information is personal to you and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or disclosures provides a general explanation and provides some examples of uses. Not every use or disclosure in a category is either listed or actually in place. The explanation is provided for your general information only.

Medical Treatment We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore we may, and most likely will, disclose medical information about you to doctors, nurses, technicians, medical students, or hospital personnel who are involved in taking care of you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside the facility who may be involved in your medical care after you leave the facility; this may include your family members, or other personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions should you become incompetent).

Payment. We may use and disclose medical information about you for services and procedures so that they may be billed and collected from your insurance company or any other third party. For example, we may need to give your healthcare information about treatment you received to obtain payment or reimbursement for the care. We may also tell your health plan and\or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment to facilitate payment of a referring physician, or the like.

Health Care Operations. We may use and disclose medical information about you so that we can run our facility more efficiently and make sure that all of our patients receive quality care. These uses may include: reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. We may also disclose information to other medical personnel for review and learning purposes. We may combine the medical information we have with medical information from other facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study healthcare and healthcare delivery without learning who the specific patients are.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care. This contact may be by phone, in writing, e-mail, or otherwise may involve the leaving an e-mail message, a message on an answering machine, or otherwise, which could (potentially) be received or intercepted by others.

Emergency Situations. In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat either to your specified health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Business Associates. We may disclose health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information, and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release health information to organizations that handle organ procurement and other entities engaged in procurement; banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transportation.

Military and Veterans. If you are a member of the armed forces, we may release health information as required by military command authorities. If you are a member of a foreign military we may release health information to the appropriate foreign military authority.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public Health Risks. Law or public policy may require us to disclose medical information about you for public health activities. The activities generally include the following:

1. To prevent or control disease, injury or disability.
2. To report child abuse or neglect.
3. To report reactions to medications or problems with products.
4. To notify people of recalls of products they may be using.
5. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
6. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Investigation and Government Activities. We may disclose medical information to a local, state, or federal agency for activities authorized by law. These may include; audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government, and other regulatory agencies to monitor the healthcare systems, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is especially true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in a dispute. We shall attempt, in these cases, to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our practice in any actual or threatened action.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We also may release health information to a funeral director as necessary for their duties.

National Security and Intelligence Activities. We may release health information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose health information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

1. In response to a court order, subpoena, warrant, summons or similar process.
2. To identify or locate a suspect, fugitive, material witness, or missing person.
3. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.
4. About the death we believe may be the result of criminal conduct.
5. About criminal conduct at the practice.
6. In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description and location of the person who committed the crime.

Inmates. If you are an inmate of a correctional institution or under the custody of the law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with healthcare, to protect your health and safety or the health and safety of others or for the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO ACCEPT OR OBJECT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your protected health information to disaster relief organizations that seek your protected health information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we

are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you.

Right to Inspect and Copy. You have a right to inspect and copy health information that may be used to make decisions about your care or payment for your care. This includes medical and billing records. To inspect and copy this health information, you must make your request in writing to the facility. We have up to 30 days to make your protected health information available to you, and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your protected health information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your protected health information in the form or format you request, if it is readily producible in such form or format. If the protected health information is not readily producible in the form or format you request your record will be provided in either our standard electronic format, or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured protected health information.

Right to Amend. If you feel that health information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request in writing to the facility.

Right to an Account of Disclosures. You have the right to request a list of certain disclosures we made of health information for purposes other than treatment, payment and healthcare operations, or for which you provided written authorization. To request an accounting of disclosures, you must make your request in writing to the facility.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis with your spouse. To request a restriction, you must make your request in writing to the facility. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment for healthcare operation purposes, and such information you wish to restrict pertains solely to a healthcare item or service for which you have paid us “out of pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out- of-Pocket-Payments. If you paid out-of-pocket (and you have requested that we not bill your health plan) in full for a specific item or services, you have the right to ask that your protected health information, with respect to that item or service, not be disclosed to a health plan for purposes of payment or healthcare operations, and we will honor that request. You must make your request in writing to the facility.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request in writing to the facility. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may request a paper copy from the facility.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you, as well as any information we may receive from you in the future. We will post a copy of the current notice in the practice. The notice will contain on the first page, in the top right hand corner, the date of the last revision and effective date. In addition, each time you visit the facility for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint with the facility, or with the Secretary of the Department of Health and Human Services. To file a complaint with the facility, contact our administrator, Spectra Eye Institute, LLC, 9849 W Thunderbird Blvd, Sun City, AZ 85351, 623-583-2020, who will direct you on how to file a complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you. *You will not be penalized for filing a complaint.*

SPECTRA EYE INSTITUTE
ADVANCE DIRECTIVE FOR HEALTH CARE DECISIONS

Spectra Eye Institute requires all staff members to recognize the statutory right of a patient who is a competent adult to decide whether to receive or refuse medical treatment. This decision may be in the form of Advance Directives for Health Care Decisions ("Advance Directive")

If an adult patient is unable to make or communicate health care treatment decisions, Spectra Eye Institute shall make a reasonable effort to locate and follow a health care directive. Spectra Eye Institute shall also make a reasonable effort to consult with a surrogate.

Spectra Eye Institute will not discriminate against a patient based on the existence or non-existence of an Advance Directive.

Any staff member of the facility who is unable or unwilling to comply with this policy shall not impede or prevent any other staff member of the facility from complying with this policy.

An attending physician who is unwilling or unable to follow the Advance Directive of a patient shall, without delay, transfer the patient, or not hinder the transfer of the patient, to another physician who will follow the Advance Directive.

At the time of the facility admission, each patient shall be provided a written summary of Spectra Eye Institute's policy on Advance Directives. Each adult patient shall also sign the Advance Directive Acknowledgment.

Advance Directives provided to Spectra Eye Institute by the patient shall be placed in the patient's medical record.

Any attempt by the patient to revoke an Advance Directive shall be honored.

Patients requesting "Do Not Resuscitate" in their Advance Directive will be requested to provide the facility with a written and notarized or witnessed copy. The request must be made known to the health care providers, including the anesthesiologist and surgeon. Spectra Eye Institute will always attempt to resuscitate a patient and transfer that patient to a hospital in the event of deterioration. Consent to resuscitative measures must be given to have a procedure performed at this facility. The patient and surrogate will be assessed for their interpretation of their request, their health status and their understanding of the impending surgical procedure. Based upon this assessment, the anesthesiologist, surgeon and health care providers of Spectra Eye Institute will relay to the patient their anticipated reactions in specific situations. The patient and anesthesiologist will be required to document their written consent on the Advanced Directives for Health Care Decisions Acknowledgment form.

PATIENT RIGHTS AND RESPONSIBILITIES

Spectra Eye Institute observes and respects a patient's rights and responsibilities without regard to age, color, race, sex, marital status, national origin, religion, culture, physical or mental disability, diagnosis, economic status, personal values or belief systems. The patient has the right to exercise his or her rights without subject to discrimination or reprisal; to voice grievance 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; and to the confidentiality of personal medical information. The patient has the right to personal privacy; to receive care in a safe setting and to be free of all forms of abuse and harassment to include: abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault, seclusion, and restraint.

The patient has the right to:

- Be treated with respect, consideration and dignity.
- Expect full recognition of individuality, including personal privacy in treatment and care. In addition, all disclosures and records will be treated confidentially and, except when required by law, patients are given the opportunity to approve or refuse their release.
- Participate in decisions involving their health care, except when participation is contraindicated.

If a patient is judged incompetent under applicable state health safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under the state law to act on the patient's behalf.

If a state court has not judged a patient incompetent, any legal representative designated by the patient in accordance with Arizona State law may exercise the patient's right to the extent allowed by law.

- Be provided with complete information concerning their diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to give such information to the patient, the information shall be provided to a person designated by the patient or to a legally authorized person.
- Be informed of procedures for expressing suggestions, complaints and grievances, including those required by state and federal regulations.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such a refusal. The patient accepts responsibility for their actions should they refuse treatment or not follow instructions of the physician or facility.
- Be informed of any human experimentation or other research/educational projects affecting their care of treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Receive copies of their medical records upon request.
- Be informed of credentials of health care professionals if requested.
- Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the patient transfer.
- Have regular assessment of pain.
- Be informed of their right to change their provider if other qualified providers are available.
- Be provided with information concerning services available at the facility; provisions for after-hours care and emergency care; fee for services; payment policies.
- Submit a complaint to the Department of Health or any other entity without fear of retaliation.
- Expect the facility to comply with Federal Civil Rights laws that assure it will provide interpretation for individuals who are not proficient in English.

The patient is responsible to:

- Provide complete and accurate information to the best of their ability about their health; any medications, including over-the-counter products and dietary supplements; and any drug or other allergies or sensitivities.
- Consent to or refuse treatment – except in an emergency.
- Report whether they clearly understand the planned course of treatment and what is expected of them.
- Follow the treatment plan prescribes by their provider.
- Inform the provider about any living will, medical power of attorney, or other directive that could affect their care.

- Provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider.
- Be respectful of all the health care providers and staff, as well as other patients.
- Be considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Accept financial responsibility for any charges not covered by their insurance.
- Payment for facility copies of the medical records the patient may request.

PATIENT RIGHTS AND RESPONSIBILITIES

If you need a translator / interpreter:

If you will need a translator or interpreter, please let us know and one will be provided for you. If you have someone who can translate or interpret confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

Advance Directives:

You have the right to information on the facility's policy regarding Advance Directives. Advance Directives will not be honored within the center. In the event of a life-threatening event, emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family. If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes. If you request, an official state Advance Directive Form will be provided to you.

Complaints:

If your complaint is not resolved to your satisfaction, you have the right to request a review by the following organizations:

Jan Amator, MBA
Administrator
Spectra Eye Institute
9849 West Thunderbird Boulevard
Sun City, AZ 85351
623-583-2020
jamator@spectraeye.com

Arizona Department of Health
150 N. 18th Ave., 4th Floor, Suite 450
Phoenix, AZ 85007
602-364-3030
www.azdhs.gov
https://app.azdhs.gov/ls/online_complaint/MEDComplaint.aspx

1-800-MEDICARE
www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

SPECTRA EYE INSTITUTE, LLC
GRIEVANCE PROCEDURE

Policy:
Spectra Eye Institute has a formal process for disposition of patient grievances. The patient or patient's representative or surrogate may file a grievance by phone or in writing. The Governing Body delegates review, investigation, and disposition of grievances to Administration. The Governing Body is informed of all grievances and may be involved in the investigation if necessary. If the patient is not satisfied with the outcome of the investigation, the grievance will be referred to the Governing Body. Investigation, action, and disposition must be documented. Subsequent references to the "patient" may include the patient's representative or surrogate.

Definitions:
Patient Grievance: A patient grievance is a written or verbal complaint by the patient regarding treatment or care that is (or fails to be) furnished. Grievances may be related to mistreatment, neglect, verbal, mental, sexual or physical abuse, patient endangerment or harm.

A complaint that is presented to Spectra Eye Institute staff and resolved at that time is not considered a grievance. Information obtained from patient satisfaction surveys are usually not considered grievances, however if a patient writes/attaches a written complaint and requests resolution, the complaint then becomes a grievance. If the patient identifies themselves on the satisfaction survey and the complaint is judged to be serious, it is considered a grievance. Billing issues are not usually considered grievances.

Procedure:
- Any patient that writes a letter or calls the center to discuss an issue or complaint is to be directed to the Administrator or Director of Nursing to begin gathering information.

- Any employee who acknowledges a patient complaint/grievance is to notify the Administrator or Director of Nursing, or Medical Director immediately.

- The letter to the patient must include the ASC contact person (Medical Director), how the grievance was addressed, the steps taken in the investigation, the results of the grievance process and the date the process was completed.

- Grievance investigations must begin immediately and be completed as soon as feasibly possible, but no later than 30 days. The patient is notified in writing of the decision. The letter must include information on what the patient can do if he/she feels that the grievance was not resolved adequately, and name of the contact person.

- In the event that the patient is not satisfied with the outcome and contacts the Center, the patient is advised that the investigation will then be referred to the Governing Body. In this case, further investigation will be completed in another 30 days. The patient will also be given information on filing a complaint with the state agency.

- Confirmed allegations of grievances regarding mistreatment, neglect, abuse, patient endangerment or harm must be reported to:

  Arizona Department of Economic Security, Division of Aging and Adult Services
  1789 West Jefferson
  #950A
  Phoenix, AZ 85007
  602-542-4446

  If appropriate, other local, state or accrediting agencies may be contacted.

- Patient satisfaction surveys that express dissatisfaction but are not considered a grievance are reviewed by the QAPI Committee for quality improvement purposes.

- Grievances will be reviewed by the QAPI Committee, Medical Executive Committee, and Governing Board. Spectra Eye Institute practices and process improvements are considered when a grievance or complaint occurs.

  All staff members will be given this information upon hire and reminded of the procedure throughout the year.

SPECTRA EYE INSTITUTE
9849 W. THUNDERBIRD BLVD.
SUN CITY ARIZONA 85351

NOTICE TO PATIENTS:

We are required as an Ambulatory Surgical Center (ASC) to notify a patient if any physician has a direct interest in the ASC. The ASC must also notify the patient that the service is available elsewhere on a competitive basis. This disclosure allows the patient to make reasoned financial decisions concerning their medical care.

In compliance with the requirements, the following physicians have direct interest in SPECTRA EYE INSTITUTE:

Daniel Briceland, MD	Stephen Hwang, MD
Craig Cassidy, DO	Richard Kootman, MD
Steven Chen, MD	Duane Mitzel, MD
Jung Dao, MD	Sanford Moretsky, DO
Pravin Dugel, MD	Shamil Patel, MD
Ofer Eytan, MD	George Reiss, MD
David Goldenberg, MD	Edward Quinlan, MD
Robert Gross, MD	Charles Schaffer, MD

ACKNOWLEDGMENT

I have read this Notice to Patients and I understand the disclosure that it contains.

Dated this _____ day of _____, 20_____

_____
Patient Signature

_____
Patient Printed Name

I have witnessed the above patient signature and have given a copy of this Notice to the patient.

_____
Employee Signature

_____
Employee Printed Name

** PLEASE COMPLETE AND BRING WITH YOU THE DAY OF YOUR SURGERY **

Patient Health and History - Spectra Eye Institute

Name: _____ Date: _____

Age: _____ Weight: _____ Height: _____ Contacts: ___Right___Left __None

Dentures: Upper ___Lower___ None___ Hearing Aids: Right___ Left___ None ____

Name of the person taking you home: _____ Relationship: _____

Home Phone: _____ Cell Phone _____

Person to notify in case of an emergency: _____ Relationship: _____

Home Phone: _____ Cell Phone _____

**PLEASE REMOVE ALL JEWELRY PRIOR TO ARRIVAL OR GIVE TO FAMILY MEMBER * *

Doctors: Please list all the main doctors involved in your care:

Name	Reason
_____	_____
_____	_____
_____	_____

Allergies: (list)	Type of Reaction	Are you sensitive to any of following?
_____	_____	Iodine: Topical ___ IV ___
_____	_____	Tape: Paper ____ Cloth ____
_____	_____	Latex ____ If so, reaction: _____
_____	_____	_____

(If more space is needed, please attach a separate sheet with list.)

Anesthesia Reactions:

Have you had any complication related to anesthesia? Yes ___ No ___ General ___ Local ___

Describe reaction: _____

Family member with complications related to anesthesia? Yes ____ No ____

MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY IN PAST OR PRESENT

Heart and Vascular
- __ Heart Attack(s) Date(s): _____
- __ Angina/Chest Pain
- __ Irregular Heart Beat/Murmur
- __ Abnormal Rhythm
- __ High Blood Pressure
- __ Heart Failure
- __ Pacemaker
- __ Mitral Valve Prolapse
- __ Other _____

Lungs
- __ Asthma/Wheezing
- __ Emphysema
- __ Bronchitis
- __ Bronchiectasis
- __ Chronic Cough
- __ TB (or family history)
- __ Shortness of Breath
- __ Sleep Apnea
- __ Other _____

Genital/Urinary
- __ Kidney or Renal
- __ Dialysis/Schedule_____
- __ Other _____ _____

Gastro-Intestinal
- __ Liver Disease
- __ Jaundice
- __ Hiatal Hernia/Reflux
- __ Other _____

Blood and Coagulation
- __ AIDS/HIV
- __ Hepatitis Type: _____
- __ Anemia
- __ Bruising
- __ Other: _____

Nervous System
- __ Stroke
- __ Seizures/Epilepsy
- __ Head/Neck Injury
- __ Other _____

Endocrine
- __ Diabetes
- __ Insulin
- __ Thyroid Disease
- __ Other _____

Musculo-Skeletal System
- __ Chronic Back/Neck Trouble
- __ Arthritis
- __ Multiple Sclerosis
- __ Other _____

Other
- __ Glaucoma __ RT __ LT
- __ Hearing Loss __ RT __ LT
- __ Breast Feeding
- __ Cancer: Type _____
- __ Recent Cough/Cold
- __ Other _____

_____

PLEASE COMLETE AND BRING WITH YOU THE DAY OF YOUR SURGERY

Type of Reaction

MEDICATIONS **I do not take any medications** _____

Please list all of the medications of which you take that require a doctor's prescription

Name of Medicine	Doses of Medicine	How Often Taken

Over-the-counter Medications: Please check any that you take

__None __Antacids __Aspirin containing products __Cold/Cough Remedies
__Diarrhea Preparation __Eye Drops __Herbal Remedies __Laxatives __Pain Medicines
__Sleeping Medicine __Vitamin/Supplements __Recreational Drugs __Other: _____

Have you taken cortisone or other steroid medicine in the last year? __Yes __No
If yes, name of drug: _____ For what? _____
Have you taken any anticoagulant (blood thinner or aspirin) medicine in the last 3 months?
__ Yes __ No Date Stopped: _____
If yes, name of drug: _____ For what? _____ Last dose: _____

Surgical History

List previous surgeries/injuries/hospitalizations or procedures (including eye surgeries):

Date: Procedures:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Other

Last Time you ate or drank: _____ am___pm ___
Do you use tobacco? __ Yes __ No Quit when? _____ Years of use: _____
Do you use alcohol? __ Yes __ No
Prosthetic devices: __Joint Replacements __ Lens Implants __Right __Left __ Other _____
Could you be pregnant? __ Yes __ No Last Menstrual Period _____

_____ _____ _____
Form Completed By Relationship Date

_____ _____
Signature of Patient or Guardian Date

SPECTRA EYE INSTITUTE
9849 W. Thunderbird Boulevard
Sun City, Arizona 85351
623-583-2020

PATIENT TUBERCULOSIS ASSESSMENT QUESTIONNAIRE

==========

Please complete the following:

_____Yes _____No Have you ever had a positive TB skin test?
_____Yes _____No Have you ever had a chest X-ray to check for TB?
*If "Yes", was chest X-ray ___Positive or ___Negative?
_____Yes _____No Have you ever been medically treated for TB?

Do you currently have any of the following symptoms?

_____Yes _____No 1. Cough lasting longer than two weeks
_____Yes _____No 2. Unexplained fever
_____Yes _____No 3. Night sweats
_____Yes _____No 4. Blood tinged sputum production (coughing up blood)

If you answered YES to any of these questions, please describe symptoms further and the reason for these symptoms. When did the symptoms begin? Have you sought treatment? If yes, what treatment was done?

_____

_____

_____

_____

_____

Patient Name (Print) _____

Patient Signature_____Date:_____

Reviewed by: _____Date:_____

Action Taken:_____

_____

_____

_____

_____

SPECTRA EYE INSTITUTE, L.L.C.

ADVANCE DIRECTIVES FOR HEALTH CARE DECISIONS ACKNOWLEDGMENT

Spectra Eye Institute, L.L.C. is required by applicable Arizona State Regulations to make you aware of your right to be involved in decisions regarding your medical care at the time of service. Specifically, you have the right to execute an Advance Directive for Health Care Decisions ("Advance Directives") either in the form of a Living Will or a Durable Power of Attorney for Health Care. To help your better understand your rights, a summary of Spectra Eye Institute's policy on Advance Directives is being furnished to you.

I have received the following information:

- A copy of Spectra Eye Institute's Patient Rights……..……yes / no
- Summary of Arizona State Law on Advance Directives……..……yes / no
- Summary of Spectra Eye Institute's Policy on Advance Directives…..…..……yes / no

I have executed an Advance Directive.. ……...……yes / no
Does it contain a **Do Not Resuscitate** clause…….…….……..yes / no

If yes, anesthesia must consult with the patient regarding the DNR clause

Notes: _____
_____
_____

Signature of Patient Date Time

_____

Signature of Anesthesiologist Date Time

_____

- I have a Living Will / Durable Power of Attorney for Health Care..… (circle appropriate)

Copy location:

(name) _____

(address) _____

(city, state, zip) _____

(telephone) _____

Signature of Patient Date Time

_____

Spectra Representative Date Time

LABEL

SPECTRA EYE INSTITUTE

9849 W. Thunderbird Road, Sun City, AZ 85351
623-583-2020

ANESTHESIA BILLING INFORMATION

Spectra Eye Institute ("Center") has several Anesthesiologists who have been credentialed and granted privileges to work at the Center. They are not employees or agents of the Center and they bill for their services separately from the Center's billing. It is not always possible for all anesthesiologists to be contracted with all insurance plans. However, even if not contracted with your insurance plan, the Anesthesiologists practicing at the Center have agreed to accept as payment in full the amount that would be allowed for such services if provided by Anesthesiologists who have entered into a contract and are in network with your insurance plan.

If your anesthesiologist at the Center is not contracted with your insurance plan, your Anesthesiologist's billing office will still submit a bill for his/her charges to your insurance plan. In the event you receive a bill from your Anesthesiologist or his/her billing office that does not appear to have been previously processed by your insurance plan, or if you receive a payment directly from your insurance plan for the anesthesia services provided to you at the Center, please contact your Anesthesiologist's billing office. If you do not have contact information for your Anesthesiologist's billing office, please call the Center at the number set forth above.

If you have any questions or concerns regarding Anesthesia billing, please do not hesitate to call us.

Spectra Eye Institute

Date: _____

Patient's Printed Name: _____

Patient's Signature: _____

Legal Guardian's Signature: _____