The Austin Diagnostic Clinic
Ambulatory Surgery Center

Patient Rights and Responsibilities

A patient's rights will include:

(a) Patients will be treated with respect, consideration, and dignity and be free from all forms of abuse or harassment. Patients may exercise rights without being subjected to discrimination or reprisal.

(b) Patients will receive care in a safe setting and will be provided appropriate privacy.

(c) Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse their release, except when release is required by law.

(d) Patients will be provided, to the degree known, appropriate information concerning their diagnosis, treatment, and prognosis. When it is 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.

(e) Patients will be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

(f) Information will be available to patients and staff concerning:

- (1) Patient rights, including those specified in subsections (a)-(e) of this section;
- (2) Patient conduct, responsibilities and participation;
- (3) Services available at the Ambulatory Surgery Center;
- (4) Provisions for after-hours and emergency care;
- (5) Fees for services; Payment policies;
- (6) Patient's right to refuse to participate in experimental research;
- (7) Advance Directives, as required by state or federal law and regulations;
- (8) The credentials of health care professionals;
- (9) Procedures for expressing suggestions, complaints and grievances, including those required by state and federal regulations.

(g) Marketing or advertising regarding the competence and/or capabilities of the organization will not be misleading to patients.

(h) Right to change his/her provider if other qualified providers are available.

(i) Appropriate information regarding the absence of malpractice insurance coverage.

(j) As a shareholder of The Austin Diagnostic Clinic, your ADC Physician has a financial interest in the Ambulatory Surgery Center.

A patient will be responsible for:

1. Providing complete and accurate information, to the best of his/her ability, about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
2. Following the treatment plan prescribed by his/her provider.
3. Providing a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider.
4. Informing his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
5. Accepting personal financial responsibility for any charges not covered by his/her insurance.
6. Respecting all the health care providers and staff, as well as, other patients.

Austin Diagnostic Clinic
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Patient Label

Communication Authorization Form

Patient Name: ________________________________

When it comes to your medical treatment, we strive to communicate with you in a timely and professional manner. There are certain occasions when family members, friends, or others might be involved in your care. As a patient, you may want our surgery center to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of those individuals with whom we can discuss your care and share your protected health information.

Please list below those individuals with whom you authorize our staff to discuss aspects related to your care.

Name: __________________________________ Relation to Patient: ____________________

Name: __________________________________ Relation to Patient: ____________________

Transportation

If you are going to receive anesthesia or moderate sedation during your visit today, it is our policy that you must have a responsible adult available to transport you home or accompany you in a taxi following your procedure or surgery. We also recommend you have a responsible adult available for twenty-four (24) hours post-procedure/post-operatively. Please list the person(s) in whose care you are being discharged today.

Name: __________________________________ Relation to Patient: ____________________

Phone:____________________________

Name: __________________________________ Relation to Patient: ____________________

Phone:____________________________

Emergency Contact

In the event of an emergency, please provide a person that we can contact, if not the same person(s) above.

Name: __________________________________ Relation to Patient: ____________________

Phone:____________________________

Patient Signature:____________________________________ Date:_____________________

Admission Personnel:_________________________________

THE AUSTIN DIAGNOSTIC CLINIC AMBULATORY SURGERY CENTER
PATIENT CONSENT TO RESUSCITATIVE MEASURES

Not a Revocation of Advance Directives
Or Medical Powers of Attorney

All patients have the right to participate in their own health care decision and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This Surgery Center respects and upholds those rights.

However, unlike in an Acute Care Hospital setting, the Surgery Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery and care after your surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative 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. Your agreement with this policy by your signature below does not revoke or invalidate any current Health Care directive or Health Care Power of Attorney.

If you do not agree to this policy, we are pleased to assist you to reschedule the procedure.

Please check the appropriate box in answer to those questions. Have you executed an Advance Health Care Directive, a Living Will, a Power of Attorney that authorizes someone to make health care decisions for you?

□ Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney
□ Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney, but I have no copy with me.
□ No, I do not have an Advance Directive, Living Will or Health Care Power of Attorney
□ I would like to have information on Advance Directives.

If you checked the first box "Yes" to the question above, please provide us a copy of that document so that it may be made a part of your medical record.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have indicated, I would like additional information, I acknowledge receipt of that information.

By:____________________________________ Date:____________________
(Patient's Signature)

If consent to the procedure is provided by anyone other than the patient, this form must be signed by the person providing the consent or authorization.

I acknowledge that I have read and understand its contents and agree to the policy as described.
By:____
(Signature)

____
(Print Name)

Relationship to Patient
□ Court Appointed Guardian
□ Attorney in Fact
□ Health Care Surrogate
□ Other

Patient Label

*** PLEASE BRING THIS FORM TO THE SURGERY CENTER ON THE DAY OF YOUR PROCEDURE**
**** You may also refer to the Texas Health and Safety Code, Chapter 166, on Advance Directives.**

Patient Label

Patient Information –
Texas Department of Health Surgery Compliance

In compliance with a new guideline from the Texas Department of State Health Services, regarding the collection of data on Race and Ethnicity for patients having Outpatient Surgery procedures at an Ambulatory Surgery Center, The Austin Diagnostic Clinic must gather and report the State's options for Race and Ethnicity.

Please mark the applicable box(es) on **BOTH** questions:

QUESTION #1:

Please check below what most accurately identifies your race:

1. _____ American Indian / Eskimo / Aleut
2. _____ Asian or Native Hawaiian or Pacific Islander
3. _____ Black or African American
4. _____ White
5. _____ Other
   (Includes all other responses not listed above. Patients who consider themselves as multiracial or mixed should choose this category.)

QUESTION #2:

Please check below what most accurately identifies your ethnic background:

1. _____ Hispanic or Latino
2. _____ Not Hispanic or Latino

Note: *Hispanics should be marked "White" for their race unless there is evidence they are of a different race (Black, Asian or Pacific Islander, or American Indian/Eskimo/Aleut). For example, many persons from the Caribbean Islands such as the Dominican Republic are of a "Hispanic" ethnicity and "Black" race.*

_______________________________ Patient/Guardian Signature

_______________________________ Date