PARK MEADOWS OUTPATIENT SURGERY
7430 East Park Meadows Drive, Suite 300 · Lone Tree, CO 80124
T: 303.706.1100 · TF: 800.844.2496 · F: 303.790.7322

PATIENT RIGHTS

OUR MISSION

The mission of Park Meadows Cosmetic Surgery, PC and Park Meadows Outpatient Surgery, LLC is to provide the best possible care to our patients with compassion, skill, knowledge, information and continued observation. Our desire is to treat each patient like we would want to be treated, with kindness and truth.

Quality of Care

You have the right to:

· Access to care regardless of sex, disability, national origin, age, color, race, religion or source of payment.
· Respectful care free from abuse, neglect or harassment, which recognizes and maintains your dignity, values, medical or surgical needs.
· Care in a safe environment with adequate staffing.
· Identification of all healthcare providers and their professional credentials.
· Care from a healthcare provider in which their professional credentials have been verified.
· Knowledge of who is primarily responsible for your care.
· Interpreters and/or special equipment to assist with any language needs.

Decision Making

You or your representative has the right to:

· Be informed of your rights before patient care is given or discontinued whenever possible.
· Receive complete and current information regarding your health status in terms you can understand.
· Participate in care planning, treatment and discharge recommendations including required/recommended continuation of healthcare following discharge.
· Receive an explanation of any proposed procedure or treatment, including risks, side effects and treatment alternatives.
· Make informed decisions regarding care and treatment.
· Participate in managing your pain effectively
· Request a specific treatment.
· Refuse or discontinue a treatment to the extent permitted by law and to be informed of the consequences of such refusal.
· Request a second opinion or to choose or change your healthcare provider.
· Have persons of your choice and your physicians promptly notified of admission.
· Review the Advanced Directives policy.
· Assign a Medical Power of Attorney.
· Formulate a Living Will.
· Accept, refuse or withdraw from clinical research.
· Receive care and/or a referral according to the urgency of your situation. When medically stable, you may be transferred to another facility if recommended by your physician.

Access to Medical Records

You or your representative has the right to:

· Request a copy of your medical records in writing via a records release form.
· Be provided a copy of your medical records within 30 days of receiving your request.

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Billing

You or your representative has the right to:

· Receive, review, and obtain a written copy of estimated charge(s) of services prior to undergoing treatment.
· A complete explanation of your bill.

Grievance Process

You and your representative has the right to:

· Voice a complaint of mistreatment, neglect, verbal, mental, sexual, or physical abuse to your healthcare providers and administrators without a fear of reprisal.
· Voice a complaint of treatment care or failure of to your healthcare providers and administrators without fear of reprisal.

File a grievance or complaint with the Administrator.
Contact: Park Meadows Cosmetic Surgery, PC
Park Meadows Outpatient Surgery, LLC
7430 East Park Meadows Drive, Suite #300
Lone Tree, CO 80124
(303) 706-1100

File a grievance or complaint with the appropriate state agencies.
Contact: DORA -Department of Regulatory Agencies
1560 Broadway, Suite #1350
Denver, CO 80202
(303)-894-7690 http://www.dora.state.co.us

Contact: CDPHE
4300 Cherry Creek Drive South
Denver, CO 80246
(303) 692-2800 or 1-800-886-7689 http://www.cdphe.state.co.us

Contact: The Medicare Hotline
1(800) 633-4227
http://www.medicare.gov or
www.cmc.hhs.gov/center/ombudsman/resources.asp

File a grievance or complaint with The Joint Commission
Contact: Office of Quality Monitoring
The Joint Commission
1 Renaissance Boulevard
Oakbrook Terrace, IL 60181
(630) 792-5636 (800) 994-6610
complaint@jointcommission.org http://www.jointcommission.org

· We will review a grievance or complaint within 14 days. A written response will be provided within 21 days.
· If such mistreatment is confirmed, the grievance will be reported to local or state authority.
· You will receive written notice of the decision(s).

Ownership

Your surgeons each have an ownership of Park Meadows Outpatient Surgery, LLC as follows:

Surgeons: Jeremy Z. Williams, MD – 50%
Christopher G. Williams, MD – 50%

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FINANCIAL POLICY

The following is a financial agreement for services rendered by Park Meadows Cosmetic Surgery, PC and Park Meadows Outpatient, LLC, Dr. Jeremy Z. Williams, Dr. Christopher G. Williams or Dr. Michael J. Miller. We strongly believe that our financial policies incorporate judicious business practices, allowing us to provide our patients with the highest quality of care, while maintaining cost-effective fees. We accept most insurance; we are in-network with some, and out-of-network with others. Please take a few moments to thoroughly read and sign this agreement regarding your obligations for services rendered.

POLICY—COSMETIC (SELF-PAY)

·A deposit is required to schedule surgical procedures as further described in your proposed Treatment Plan.
·Surgical fees, facility fees and anesthesia fees are due in full one week prior to surgery.
·Any adjunct procedures, deemed medically necessary at the time of surgery, as discussed, will be an additional expense.
·All treatments/injections must be paid in full at the time of service. This includes all forms of payment from 3rd parties (ie Brilliant Distinctions).

POLICY—INSURANCE

·Full payment of your estimated out-of-pocket expense is due at your pre-surgical visit or one week prior to surgery. Because this is an estimate there may be additional expense due, or a refund due, once your insurance company issues its' Explanation of Benefits. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.
·You will receive multiple Explanation of Benefits from the insurance company as well as multiple invoices from other providers during your surgery. The multiple
providers include: surgeons, anesthesiologists, surgery center or hospital, pathology, etc.
·Any adjunct procedures, deemed medically necessary at the time of surgery, will be an additional expense.
·It is a patients' responsibility, prior to surgery, to verify insurance coverage and benefits. Even though it is your responsibility, as a courtesy we verify with your insurance company if a pre-determination, a pre-authorization or a pre-certification is necessary prior to any surgical procedure. As a courtesy, we will bill your insurance company for the date of service. Failure to provide all necessary billing information will result in full patient financial responsibility.
·If the insurance company pays patient directly, the patient must forward the check to us within 2 weeks.
·Any service determined as a non-covered benefit or excluded service by the insurance company is the patient's responsibility.

IN-NETWORK: Our office will conduct the pre-authorization with your insurance provider. As a courtesy, we will verify your eligibility, benefits and out of pocket payment requirements with your insurance provider (primary and secondary insurances). We will also notify you of any upfront payment requirements. It is our contractual obligation to collect all copays, deductibles and coinsurance from the patient prior to surgery. We will promptly refund any overpayments made on your part and we will collect on any underpayments determined by your insurance policy.

OUT-OF-NETWORK: A consultation fee is due at the time of service unless otherwise noted by staff. Our office will bill all non-contracted insurance plans as a courtesy to our patients. However, we expect full payment at the time of service. Claims will be submitted and the patient is responsible for the balance billed.

THIRD-PARTY PROVIDERS

·I understand that third-party providers may be involved (as an example, anesthesiologists) if I have a surgical procedure. I authorize third-party providers to release to my insurance company any and all information necessary for the processing of claims.

AVAILABLE FINANCING OPTIONS

·We accept cash, checks, Visa, Master Card, Discover, and American Express. Please note that in the event a check is returned to our office due to insufficient funds, a $25 charge will be added to the account.
·Financing through Care Credit is available to qualified applicants. Rates are set by each individual financing company and are subject to change.

LATE APPOINTMENT / NO SHOW / CANCELLATION POLICY

·I understand that if I am late for an appointment, the appointment may be rescheduled.
·Cancellations will be accepted up to 24 hours in advance of the scheduled appointment. Any no-show or cancelled appointment within 24 hours may be subject to a $50.00 cancellation fee.

IF YOU HAVE ANY QUESTIONS REGARDING THIS FINANCIAL POLICY PLEASE ASK FOR CLARIFICATION PRIOR TO SIGNING BELOW.

I have read and understand the Park Meadows Cosmetic Surgery, PC and Park Meadows Outpatient Surgery, LLC Financial Policy and agree to abide by its terms.

_____ _____

Signature of Patient or Guardian Date

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PATIENT RESPONSIBILITIES

PROVIDING INFORMATION

You have the responsibility to:

· Provide accurate and complete information about your present complaints, past illnesses, hospitalizations, medications and other health-related matters.
· Report perceived risks in your care and unexpected changes in your condition.
· Understand your treatment plan and ask questions when needed.
· Understand your pre- and post- operative instructions, asking questions if you do not understand.
· Provide accurate and updated information for insurance and billing.

INVOLVEMENT

You have the responsibility to:

· Actively participate in your treatment by following your recommended treatment plan.
· To call us at any time if you have questions or concerns about your care or progress.
· Return for any follow up visits as requested.
· To take full responsibility for your actions, should you choose to refuse treatment.

RESPECT AND CONSIDERATION

You have the responsibility to:

· Act in a respectful and considerate manner towards healthcare providers, other patients, and visitors.

INSURANCE BILLING

You have the responsibility to:

· Know the extent of your insurance coverage; benefits, deductibles and pre-authorization requirements.
· To assume and fulfill financial responsibility for health care which is provided to you, your dependent, or designated minor. We will assist you filing appropriate claims with your insurance provider, as a courtesy; however, final responsibility for all uncovered charges rests with you.
· Call the billing office with questions or concerns (303) 706-1100.

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ASSIGNMENT OF BENEFITS

I hereby appoint as my authorized representative, and assign to Park Meadows Cosmetic Surgery, PC/Park Meadows Outpatient Surgery, LLC all my right, title, and interest in and to, and relating in and to the recovery of, any and all health care and/or surgical benefits otherwise payable to me or to which I am entitled for medical treatment, including major medical, rendered by Park Meadows Cosmetic Surgery, PC/Park Meadows Outpatient Surgery, LLC.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

AUTHORIZATION
I also specifically authorize my authorized representative to do the following on my behalf:

1. File and prosecute any required claim, appeal or grievance with my health plan and/or health insurer for payment of medical claims submitted by or on behalf of my authorized representative.
2. File any required complaint, appeal or grievance with the Department of Regulatory Agencies Insurance Division, the Department of Labor, or any other regulatory agency for payment of medical claims submitted by or on behalf of my authorized representative.
3. File any required litigation or arbitration against my health plan and/or health insurer for payment of medical claims submitted by or on behalf of my authorized representative, and to exert or receive any other rights or benefits under my health plan with respect to the treatment rendered by Park Meadows Cosmetic Surgery, PC/Park Meadows Outpatient Surgery, LLC, and I specifically authorize my authorized representative to name me and the patient, if I am executing this document on the patient's behalf, as plaintiff(s) in such litigation or arbitration against my health plan and/or health insurer or otherwise pursue claims on my behalf. I hereby also assign to Park Meadows Cosmetic Surgery, PC/Park Meadows Outpatient Surgery, LLC any right to recover their full billed charges and any expenses and fees incurred for pursuing the claim, as well as all rights, statutory or contractual, to any additional recovery related to my health benefits such as treble damages, punitive damages and/or penalties.
4. Discuss my personal health information or that of the patient with my health plan and/or health insurer.
5. I specifically authorize any law firm appointed by my authorized representative to file litigation or arbitration on my behalf and on behalf of my authorized representative with respect to any or all of the items listed in Point 1 through 4 above.

I have read and understand the Park Meadows Cosmetic Surgery, PC and Park Meadows Outpatient Surgery, LLC Assignment of Benefits Policy and agree to abide by its terms.

_____ _____
Signature of Patient or Guardian Date

_____
Printed Name of Patient or Guardian