In an effort to provide premium health care service to their patients, the physicians listed below have proudly invested in Crescent City Surgical Centre. Their involvement in the management and operations of this hospital enable our staff to provide the care that you deserve.

The following have an ownership interest in Crescent City Surgical Hospital:

Najeeb Thomas, MD
Tom Lavin, MD
Chad Millet, MD
Michael Thomas, MD
Rachel Moore, MD
Clark Warden, MD
James Redmann, MD
Matthew French, MD
Rand Voorhies, MD
Kevin Martinez, MD
Lucien Miranne, MD
Everett Robert, MD
Richard Meyer, MD
Lance Estrada, MD
Kevin Watson, MD
Felipe Ramirez-Terrassa, MD
Louisiana Children's Medical Center
Andrew Todd, MD
Field Ogden, MD
Will Junius, MD
Simon Finger, MD
Claude Williams, MD
Michael McNulty, MD
Douglas Lurie, MD
Knight Worley, MD
Scott Buhler, MD
Sean Mayfield, MD
Mike Adinolfi, MD
Elliott Black, MD
Eileen Black, MD
Richard Vanderbrook, MD
Richard Vanlangendonck, MD
Ramon Rodriguez, MD

You have been referred by Dr. _____ to Crescent City Surgical Centre for the following health care services:

_____

_____

Patient Acknowledgement

Patient Name: _____

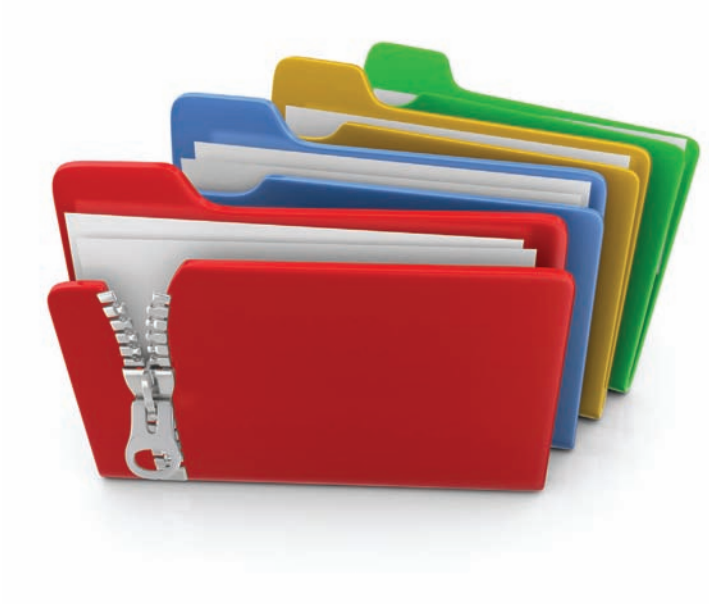
Patient Signature: _____

Date: _____

REV 05/15/2017

Crescent City Surgical Centre
Notice of Privacy Practices

3017 Galleria Drive, Metairie, LA 70001
504-830-2500 www.ccsurg.com
Privacy Officer: Teresa Woodle
504-830-2445 twoodle@ccsurg.com



Your Information. Your Rights. Our Responsibilities.

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.

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.

Get an electronic or paper copy of your medical record	• 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.
Ask us to correct your medical record	• 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.
Request confidential communications	• 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.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- 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.

Get a list of those with whom we've shared information

- 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.

Get a copy of this privacy notice

- 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.

Choose someone to act for you

- 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.

File a complaint if you feel your rights are violated

- 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 **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

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 • Contact you for fundraising efforts *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
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

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.*

continued on next page

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

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.

We do not create or maintain psychotherapy notes.
We will never share any substance abuse treatment records without your written permission.

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.**

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.

July 1, 2017

This Notice of Privacy Practices applies to the following organizations.

Crescent City Surgical Centre

Privacy Officer: Teresa Woodle 504-830-2445 twoodle@ccsurg.com

Patient Label

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided with a copy of Crescent City Surgical Centre's Notice of Privacy Practices.

Patient Signature: _____ Date: ___/____/____

If completed by a **patient's personal representative, please print and sign below.**

_____ _____

Personal Representative **(Print)** Personal Representative's **Signature**

_____ Date: ____/____/____

Relationship

For Crescent City Surgical Centre use only.

Complete this section if this form is not signed/dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Crescent City Surgical Centre's Notice of Privacy Practices but was unable to for the following reason:

□ Patient refused to sign □ Patient unable to sign

□ Other _____

_____ Date: ____/____/____

Employee Name

This form should be placed in the patient's medical record.

Revised July 2017

PATIENT RIGHTS & RESPONSIBILITIES

Patients have the right to.....

- Be informed of their rights and responsibilities.
- Have a family member, chosen representative and/or their physician notified promptly of admission to the hospital.
- Receive treatment and medical services without any type of discrimination.
- The right to be treated with consideration, respect and recognition of their individuality, including the need for privacy in treatment
- Be informed of the names and functions of all physicians and other healthcare professionals providing their direct care.
- Receive the services of a translator or interpreter to facilitate the communication between the patient and the hospital's healthcare professionals.
- Participate in the development and implementation of their plan of care.
- Make informed decisions regarding their care.
- Be informed of their health status, involved in care planning and treatment, allowed to request or refuse treatment.
- Be included or to refuse to be included in experimental research.
- Be informed if the hospital has authorized other institutions, and to refuse to allow the institutions to participate in their treatment.
- Formulate advance directives and have physicians and other healthcare professionals about any continuing healthcare requirements after their discharge.
- Receive assistance from their physician and appropriate healthcare professionals in arranging for required follow-up care.
- Have their medical records kept confidential.
- Have access to their medical records within a reasonable time frame.
- To be free of restraints of any form that are not medically necessary.
- Be free of all forms of abuse and harassment.
- To receive care in a safe setting.
- Examine and receive an explanation of their bill and may receive information relating to financial assistance available.
- Have a full explanation if they are being transferred to another facility.
- Be informed in writing about the hospital's policies and procedures for initiation, review and resolution if patient complaints, including the address and telephone number of where to file complaints with the Department of Health and Human Services.

Patients have the responsibility to.....

- Provide information
- Follow instructions
- Follow hospital rules and regulations
- Ask questions
- Accept consequences of their decisions
- Meet financial obligations
- Show respect and consideration

_____ _____ _____

Patient Signature Date

_____ _____ _____

Witness Date

Crescent City Surgical Centre

Patient Agreement (rev 9/21/2016)

PATIENT LABEL

A. Consent for Uses & Disclosure of Health Information

I consent to CCSC and its affiliates using and disclosing my health information for Treatment, Payment, and Health Operations. I also acknowledge I have received/been offered a copy of the hospital's Notice of Privacy Practices that describes in details such uses and disclosures as well as my rights with respect to my personal health information. I understand that Telemedicine (live two-way audio and video) may be used for diagnosis, therapy, follow-up and/or education. The system incorporates network and software security protocols to protect the confidentiality of PHI (Protected Health Information).

B. **Patient Rights and Responsibilities**

I acknowledge that I have received a copy of the Patient Rights and Responsibilities handout. I also confirm that I have an opportunity to ask questions about the information provided to me and understand it.

C. **Assignment of Benefits and Reimbursement Rights**

I agree to assign all benefits, reimbursement and appellate rights to which I am entitled and which are otherwise payable to me, to CCSC, its affiliates and my treating physician(s) to admit retain and treat me as a patient. My signature below affirms that my understanding and acceptance of my financial responsibility to the hospital, its affiliates, and my treating physician(s) for all charges related to services not paid within thirty (30) days of the bill date or for any amount unpaid by insurance. I also unconditionally guarantee payment of all cost for my hospital stay such as hospital and physician services, facility uses, medications, food and other services and supplies provided to me as a patient, additionally, if payment in full is not received within ninety (90) days of the last day of service and if my account is referred to a collection agency, I agree to pay collection agency fees of twenty five (25) percent. I further agree to pay attorney's fee of thirty (30) percent of the amount due if the hospital has to refer my financial obligation to an attorney for collection. This assignment shall include the authority and right to institute legal action to recover ALL amounts due as a result of said services rendered including any and all statutory penalties which may be claimed and collected.

D. **Government Health Care Programs**

I understand that if I falsely represent and / or provide false documentation to claim eligibility for Medicare, Medicaid, or other government health programs benefits. I risk being charged by the government for fraud and if convicted, will be subject to fines and other imprisonment.

E. **Patients" Right to Receive An Itemized Statement of Charges**

I have been advised that Louisiana Law entitles me to receive an itemized statement of billed services within ten (10) business days after discharge. I further understand the hospital's business office will provide my itemized statement only on my request.

F. Release of Responsibility of Valuables

I understand and accept full responsibility for all articles (money, jewelry, dentures, eyeglasses, clothing and all other forms of my personal property) which I bring or others bring on my behalf to the hospital. The hospital and its employees are not responsible for loss of or damage to property which is not specifically deposited for safekeeping.

G. Consent for Medical and/or Surgical Treatment

I am aware that medical and surgical treatment has inherent risks and outcomes are not always predictable despite appropriate care. I acknowledge that no guarantees have been made by the hospital or its affiliates or my treating physician(s) as to the anticipated outcome of my pending medical and/or surgical, or other treatment as is deemed necessary by my attending physician.

I HAVE READ ALL OF THE ABOVE AND CERTIFY I UNDERSTAND AND AGREED TO ALL PROVISIONS .

_____ **_____**

Signature of Patient **Signature of Authorized Patient Representative**

Date: _____/_____/_____ Time: _____ **Relationship to Patient_____**

Signature of Witness:_____ **Reason Patient cannot sign on his/her behalf._____**

Crescent City Surgical Centre Authorization for the Use and Disclosure of Protected Health Information

Place Patient Label in Box

Rev 1/2013

Patient Legal Name : _____ Date of birth: ____/____/____

Social Security Number: _____/_____/_____

Address _____ Telephone No._____

City _____ State_____ Zip Code _____

I hereby authorize Crescent City Surgical Centre to: ☐ Disclose ☐ Request
Medical record information (protected heath information) of the patient listed above to / from:

Name / Title: _____

Address: _____

Purpose: _____

For treatment date(s) _____

Type of Access Requested:	**Entire record copied unless selected portions of PHI are specified:**		
☐ Copies of the record	☐ Entire Record	☐ Abstract / Pertinent	☐ EKG (1st & last)
	☐ H & P	☐ Physician Orders	☐ EEG
☐ Inspection of the record	☐ Consult Report	☐ Admit Note or ED Record	☐ Last Chest X-Ray
	☐Operative Report	☐ Last Respiratory Care Notes	☐ CEC, PEC
	☐ Rehab Services	☐ Last CBC, Urinalysis, Serology	☐ Discharge Summary
	☐ Cardiac Studies	☐ Patient Care Summary	☐ X-Ray Film
	☐ Face Sheet	☐ Special Lab Reports	☐ Other _____
	☐ Nursing Notes	☐ Special X-Ray Report	
	☐ Medication Record	☐ Progress Notes	

_____ I acknowledge and hereby consent to such, that the released information may contain alcohol and drug, psychiatric, HIV, or genetic information, and/or any other sensitive information.
INITIALS

This authorization shall expire upon the expiration Date or Event (if I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed:_____

- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company for services already rendered.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.
- Fee / charges will comply with all laws and regulations applicable to release of information.
- I understand authorizing the use of disclosure of the information identified above is voluntary. I do not need to sign this form to ensure healthcare treatment.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
Signature of Patient/ Legal Representative Date

If signed by representative, relationship to patient: _____

_____ _____
Signature of Witness Date

ALL ASPECTS OF THIS FORM MUST BE FILLLED OUT <u>COMPLETELY.</u>

Name of the hospital or affiliate employee who processed this authorization

_____ _____ _____
(Please print: First Name, Middle Initial and Last Name) Department

Date Authorization Processed (mm/dd/yyyy): _____/_____/_____ Medical Record #: _____

3017Galleria Dr.
Metairie, La. 70001
Phone: 504-830-2500
Fax: 504-830-2469

To our patients:

We want to thank you for choosing Crescent City Surgical Centre for your services.

Crescent City Surgical Centre may not contract with all of the insurance companies licensed to do business in the state of Louisiana. However, Crescent City Surgical Centre *will honor* your in network benefits.

- If your in network benefit to the hospital is a copay, then the hospital will collect only the copay.
- If the out of network benefit is a higher deductible and/or, coinsurance, the hospital will only collect the in network deductible and /or coinsurance.
- You may receive separate bills for services provided by other health care professionals practicing at the hospital, such as anesthesiologists, radiologists, pathologists, etc. While these professionals may or may not be contracted with your insurance company***, they will also honor your in-network benefits***.
- Please feel free to direct any questions you may have about these issues to our administrative admissions staff.

Due to the out of network arrangement, the insurance company may mail the payment directly to you. If this is the case please follow the instructions below:

1. Make a copy of all paperwork (including check)
2. Endorse the back of the check and either mail or bring the check along with the Explanation of Benefits to the facility
3. If you have deposited the check into your personal checking account, then make your check payable to Crescent City Surgical Centre
4. Mail check to Crescent City Surgical Centre, 3017 Galleria Dr., Metairie, La. 70001

If you receive a check from your insurance company and do not forward that payment to Crescent City Surgical Centre you will be billed for the services in full. Thank you in advance for your cooperation. If you have any questions please call Nancy Leblanc at (504) 830-2525 or LaDonna Orgeron at (504) 830-2431 or Debbie Charpio at (504) 830-2422.

_____ ____/____/____
PATIENT SIGNATURE

_____ ____/____/____
BUSINESS OFFICE REPRESENTATIVE

Rev. 5/2016

LIMITED POWER OF ATTORNEY

UNITED STATES OF AMERICA
STATE OF LOUISIANA
PARISH OF JEFFERSON

The undersigned PRINCIPAL, who declares that he/she is of legal age and further that he/she does by these presents make, ordain, constitute and appoint the hereinafter named AGENT as ATTORNEY-IN-FACT (hereinafter referred to as AGENT), who is the full age of majority, to be his/her true and lawful AGENT, hereby giving and granting unto said AGENT full power and authority for him/her, in his/her name, place and stead, to do and perform all the things and acts specified herein and in the numbered paragraph(s) indicated below.

PRINCIPAL further authorizes and empowers his/her said AGENT to do and perform any and every act, matter and thing whatsoever, as shall or may be requisite and necessary in order to effectuate the purpose for which this power of attorney is granted, as fully and with like effect as if PRINCIPAL had been personally present and had done any such thing, performed any such act, and/or signed all and any such document, deed, note, contract, application or other agreement, PRINCIPAL hereby ratifying and confirming any and all things done by his/her said AGENT and adopting them as his/her own act and deed.

PRINCIPAL further expressly stipulates that any obligation which may arise in the interpretation hereof shall be liberally construed so as to effectuate the purpose hereof and to validate all things done by AGENT. Whenever used herein, the singular number shall include the plural, and the masculine gender shall include all genders.

The purpose for which this power of attorney is granted is to allow, authorize, and direct my AGENT(S) to do any and all acts whatsoever necessary to pursue and obtain and confirm health care coverage and reimbursement from my health care insurer, third party administrator, or other responsible party payor, for any and all medical services rendered or to be rendered by Crescent City Surgical Centre Operating Co., LLC, which includes the right to institute legal action or file suit.

This power of attorney is effective as of this date, and has an unlimited duration.

PRINCIPAL: _____

Name: _____

Address: _____ City, State: _____,____

Social Security No.: _____:_____:_____

AGENT(S):

Stacy Saavedra and/or designee of Crescent City Surgical Centre Operating Co, LLC
3017 Galleria Drive, Metairie, Louisiana 70001

THUS DONE AND PASSED, in multiple originals, at the City and State aforesaid on the date set forth, in the presence if the undersigned competent witnesses, who have hereto signed their names with said PRINCIPAL, after due reading of the whole.

WITNESSES:

_____ _____
(Signature) Date PRINCIPAL Date

_____
(Printed Name)

_____ Stacy Saavedra
(Signature) Date AGENT/HOLDER of Power of Attorney

_____ Rev 9/2016
(Printed Name)