George B. Winton, M.D.
Diplomate American Board of Dermatology
F.A.C. MOHS Micrographic Surgery and Cutaneous Oncology

Steve L. Peterson, M.D.
Diplomate American Board of Otolaryngology
A.A.C. MOHS Micrographic Surgery and Cutaneous Oncology

We would like to take this opportunity to welcome you as a patient and to thank you for choosing Tri-Cities Outpatient Surgery Center.

Enclosed in this packet you will find the following items:

- Advanced Directives information and the explanation of its use
- Advance Care Plan form
- Appointment of Health Care Agent form
- Tri-Cities Outpatient Surgery Center Patients Rights
- Physician disclosure of ownership

Due to new federal regulations your procedure will be rescheduled if this packet is not reviewed prior to your appointment time. Please take time to review it and **BRING THIS PACKET WITH YOU TO YOUR APPOINTMENT**. You do not need to complete the forms unless you choose to do so. When you arrive on the date of your procedure, you will be asked to sign a form that you have reviewed this information.

It is very important to your scheduled procedure, that you review this packet. Remember, you do not need to complete the paperwork unless you wish to establish an Advance Directive or Healthcare Agent. If you need assistance or have any questions regarding this matter, please feel free to contact our office at 423-722-0563.

Thank you,

Staff of Tri-Cities Outpatient Surgery Center

1009 N. STATE OF FRANKLIN ACCESS ROAD STE.B • JOHNSON CITY, TN • 37604 •
PHONE: 423-722-0563 •FAX: 423-722-0577

APPOINTMENT OF HEALTH CARE AGENT

(Tennessee)

I, ________________________________, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:

____
Name

____
Address

____
City State Zip Code

(______)______________________________________
Area Code Home Phone Number

(______)______________________________________
Area Code Work Phone Number

(______)______________________________________
Area Code Mobile Phone Number

Alternate:

____
Name

____
Address

____
City State Zip Code

(______)______________________________________
Area Code Home Phone Number

(______)______________________________________
Area Code Work Phone Number

(______)______________________________________
Area Code Mobile Phone Number

____
Patient's name (please print or type) Date

____
Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, **either** block A **or** block B must be properly completed and signed.

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named above.
I witnessed the patient's signature on this form.

____
Signature of witness number 1

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

____
Signature of witness number 2

Block B Notarization

STATE OF TENNESSEE
COUNTY OF __________________

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: ______________________________

____
Signature of Notary Public

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, ______________________________________, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name: ________________________________ Phone #: ______________ Relation: ______________________
Address: ____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: ________________________________ Phone #: ______________ Relation: ______________________
Address: ____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions **(you can check as many of these items as you want)**:

☐ **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

☐ **Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

☐ **Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.

☐ **End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. **Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.**

☐ ☐ Yes No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ ☐ Yes No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
☐ ☐ Yes No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ ☐ Yes No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

PLEASE SIGN ON PAGE 2

Other instructions, such as burial arrangements, hospice care, etc.: ______________________________________
____
____
____
____
(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: ____________
____
____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: ________________________________ DATE: ____________________
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

   ____
   Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

   ____
   Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF ________________________

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: ___________________ ________________________________
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005
Acknowledgement to Project GRACE for inspiring the development of this form.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of the Doctor's office: You have the following rights with respect to your Protected Health Information.

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted.
2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("NOTICE") by making a request at our office.
3. Right to inspect and copy your health record and billing record. You may exercise this right by delivering the request in writing to our office using the form we provide to you upon request; appeal a denial of access to your protected health information except in certain circumstances.
4. Right to request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request. (The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
5. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.
6. Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide your upon request.

If you want to exercise any of the above rights, please contact Privacy Officer at (423)929-7546 • 1009 N. State of Franklin Access Road, in person or in writing, during normal business hours. S[he] will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

OUR RESPONSIBILITIES

The office is required to:

- Maintain the privacy of your health information as required by law.
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we cannot accommodate a requested restriction or request.
- Accommodate your reasonable request regarding methods to communicate health information with you.
- Accommodate your request for an accounting of disclosures.

We reserve the right to amend , charge, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of our "NOTICE" or by visiting our office and picking up a copy.

TO REQUEST INFORMATION OR FILE A COMPLAINT

If you have questions, would like additional information or to report a problem regarding the handling of your information, you may contact

1009 N. State of Franklin Access Road
Johnson City, TN 37604
Telephone (423)929-SKIN (7546)
Fax (423) 929-7968

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaints to Privacy Officer. You may also file a complaint by mailing it or e-mailing it to the secretary of Health and Human Services as a condition of receiving treatment from our office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Effective Date: May 28, 2003

Tri-Cities Outpatient Surgery

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT "HIPAA"

1009 N. State of Franklin access Road
Johnson City, TN 37604
Telephone (423) 929-SKIN (7546)
Fax (423) 929-7968

Notice of Privacy

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!

This privacy notice is provided to you as a requirement of a federal law, Health Insurance Portability and Accountability Act (HIPAA). Under this law, your protected health information (PHI) is confidential and protected. This privacy notice describes how we may use and disclose your health information for purposes of treatment, payment, and health care operations. Protected health information (PHI) is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Treatment: We will use and disclose your PHI to provide you with treatment or services. For example, a nurse, physician, or other member of our health care team will obtain treatment information and record in your health record. We may also disclose information during the course of your treatment to another specialist for his/her input, pharmacy who fills your prescriptions, or a family member who assists in your care.

Payment: We will use disclose your PHI for payment purposes. For example, we may contact your health insurance company to verify benefits, coverage, and medical necessity.

Health Care Operations: We will use and disclose your PHI to conduct internal operations including, but not limited to , quality improvement, protocol and clinical guideline development, training programs, coding audits, credentialing, and medial review.

Special Uses: We may use your PHI to contact you with appointment reminders, treatment alternatives, research studies which may benefit your treatment, or other health related information which may be of interest to you.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

HIPAA rules allow us to use or disclose PHI without your consent or the opportunity to object under the following circumstances:

1. *Required by law:* We will disclose PHI when local, state, or federal law requires us to report suspected abuse, neglect, gunshot wounds, or similar injuries.
2. *Public Health Reasons:* As required by law, we may disclose vital statistics, disease, product recall, or exposure to communicable disease.
3. *Victims of Abuse, Neglect, or Domestic Violence:* We can disclose protected health information to governmental authorities to the extent the disclosure is authorized by statute or regulation and in the exercise of professional judgment the doctor believes the disclosure is necessary to prevent serious harm to the individual or other potential victim.
4. *Oversight Agencies:* Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations: inspection; licensures or disciplinary actions, and for similar reasons related to the administration of healthcare.
5. *Judicial/Administrative Proceedings:* We may disclose your protected health information in the course of any judicial or administrative proceedings as allowed or required by law with your consent, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process.
6. *Law Enforcement:* We may disclose your protected health information for law enforcement purposes as required by law , such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury.
7. *Coroners, Medical Examiners and Funeral Directors:* WE may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.
8. *Organ Procurement Organizations:* Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of donation and transplant.
9. *Research:* We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
10. *Threat to Health and Safety:* To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.
11. *For Specialized Governmental Functions:* We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.
12. *Correctional Institutions:* If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.
13. *Workers Compensation:* If you are seeking compensation through Workers Compensations, we may disclose your protected health information to the extent necessary to comply with laws relating to workers compensation.

In all other situations, we will use and disclose your PHI after obtaining your written authorization. The authorized will be specific in terms and can be revoked by you at any time by written revocation.

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"Disclosure of Physician Ownership"

A Corporation formed by the physicians of Tri-Cities Skin & Cancer owns this facility.

These Physicians have become owners as a result of their commitment to quality healthcare and to better provide services to their patients.

Therefore; your physician is an owner of this facility. Please be advised of the following:

- This facility may have a financial relationship with your physician as indicated above.
- A schedule of typical fees for the facility is available upon request.
- You have the right to choose where you receive your services, including that of an entity in which your physician may have financial relations.

1009 N. STATE OF FRANKLIN ACCESS ROAD STE.B • JOHNSON CITY, TN • 37604 • PHONE: 423-722-0563 OR 423-722-0869 •FAX: 423-929-7968