Advanced Surgery Center, LLC
10110 Molecular Drive Suite 100
Rockville, MD 20850
301-838-0437

As a patient of Advanced Surgery Center, LLC you have the right to receive the following information in advanced of the date of your procedure.

Please read, fill out or sign the following pages and bring them with you day of procedure.

ADVANCED SURGERY CENTER, LLC
10110 Molecular Dr. Suite 100
Rockville, MD 20850
301-838-0437

[Patient Label]

Procedure Date: _____

***Advanced Surgery Center is committed to providing the highest level of patient care.** To achieve this objective we ask our patients or their caretaker to complete a brief patient satisfaction survey after their visit.

Please write legibly and provide the E-MAIL address to forward the survey to in the space below:

If you do not have access to email or a computer please let us knows and we will provide you with a paper version of the survey to complete and return to us.

Privacy Statement: We are committed to protecting the confidentiality of our patient's information and identities and under no circumstances will your information be disclosed or used for marketing purposes.

***For the purpose of sending a copy of the results from your procedure to the doctors of your choice please provide us with the following information:**

Primary Care Physician Name:

Phone **#**

Referring Physician Name:

Phone **#**

***Advanced Directives:** **You have the right to the Center's information on Advanced Directives. If you would like a copy of this information please ask at the front desk when you arrive for your appointment.**

Advanced Surgery Center, LLC
10110 Molecular Dr. Suite 100
Rockville, MD 20850
301-838-0437

Patient Label

Person **driving** you home: (Name) _____

Relation to the patient: _____

Best number to call ride: _____

ALL PATIENTS MUST HAVE RIDES
ALL RIDES MUST COME IN TO SIGN YOU OUT
NO LATER THAN 4:00 PM

Please Check One:

☐ Waiting in Lobby

☐ Call Length of time needed to return to Advanced Surgery Center _____

☐ Leaving, will return at _____(time)

Patient's primary language _____

Interpretation Needed? _____

Interpreter's Name_____

Interpreter's Relation to patient _____

FOR OFFICE USE ONLY

Estimated D/C Time: _____ Escort Initials_____ Date_____

Advanced Surgery Center
301-838-0437
Post Procedure Contact Information

Best number to reach patient between 8am and 4pm

Needs Interpreter ☐ Chinese ☐ Spanish ☐ Vietnamese ☐ Korean

_____ **Cell Home Work Email if deaf**

Okay to leave a message? _____Yes _____No
May we speak with anyone who answers if the patient is not at home? _____Yes _____No

---

INFORMATION BELOW TO BE COMPLETED BY SURGERY CENTER STAFF ONLY

Post Procedure Call

How are you doing since the procedure? _____

Did you experience any difficulties after your procedure? _____

Post-Colonoscopy: any rectal bleeding? ☐ Yes ☐ No ☐ N/A

Any problems drinking fluid or swallowing food? ☐ Yes ☐ No

Reminder given to patient to follow up with Doctor? ☐ Yes ☐ No

Any additional instructions or comments made to/or by the patient:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Time talked to pt._____ Time left message_____ Time no answer _____

Completed By: _____ Date: _____

Revised 8.16, 6.18, 4.19

Patient Label

ADVANCED SURGERY CENTER, LLC

Patient Name_____ **Patient Medication Record**

Date of Birth:____/_____/_____

Date ____/____/_____

PLEASE COMPLETE BEFORE ARRIVING TO ADVANCED SURGERY CENTER

Allergies with Reactions:

List all prescriptions, over the counter (non-prescription) medications and herbal suplements you take regularly and only as needed

Name of Medication	**Dose** (mg, units, puffs)	**When/How** often do you take this medication?	**When** did you take last take this medication?	**Resume Home Medications** ☐

New Medications:

PATIENT DOES NOT REMEMBER DRUG NAMES OR DOSES ☐

REVISED 09-12-2016, 10/2017

ADVANCED SURGERY CENTER, LLC

Patient Bill of Rights

1. *To expect to be treated with respect, consideration, and dignity while receiving care, treatment, procedures, and other services.*
2. *To receive care in a safe environment.*
3. *To be provided privacy and security of self and belongings during the delivery of care.*
4. *To exercise your rights without discrimination or reprisal.*
5. *To be free from all forms of mental and physical abuse, free from neglect, exploitation and harassment by ASC staff, visitors and other patients. Restraints, drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.*
6. *Full consideration of privacy concerning patient medical care program. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.*
7. *To be assured confidential treatment for disclosure of records and afforded the opportunity to approve or refuse the release of such information, except as otherwise permitted by law of third party payment contract and when release is required by law. This facility has established policies to govern access and duplication of patient records.*
8. *To know the name and function of any person providing health care services for you.*
9. *To know names and professional relationships of other physicians who may care for you in the absence of your attending physician.*
10. *To receive information, to the degree known, regarding your diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to you, the information is provided to a person designated by the patient, or to a legally authorized representative.*
11. *To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. To be informed of the medical consequences if refusing treatment.*
12. *To refuse to participate in experimental research.*
13. *The right to refuse treatment or change physicians if other qualified providers are available.to the extent permitted by law and*
14. *The patient may request a second opinion.*
15. *To expect a reasonable response to any reasonable request you may make for service.*
16. *To expect communication in the language which you understand. If you need an interpreter please let us know in advance and one will be provided. If you have someone who can translate confidential medical information, please bring them with you.*
17. *To receive treatment without regard to race, color, creed, religion, sex, national origin, disability or source of payment, except for fiscal capability thereof.*
18. *To know services available, such as provisions for after hours or emergency care, educational material available, and policies concerning payment of fees.*
19. *To examine and receive an explanation of your bill, regardless of the source of payment.*
20. *To expect reasonable continuity of care and to know in advance the time and location of appointments, as well as the physician providing the care.*
21. *To designate any area where you are cared for or treated as a non-smoking area.*
22. *To leave the facility even against the advice of your physician.*
23. *To have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on your behalf.*

ADVANCED SURGERY CENTER, LLC

Patient Bill of Rights

24. *To appropriate assessment and management of pain.*
25. *Know which facility rules and policies apply to patient conduct.*
26. *Right to voice grievances.*
27. *To know our policy on Advance Directives: ASC acknowledges your right to have an Advance Directive and will add it to your medical record. However, should an untoward event occur during your surgery, it is our policy to stabilize you and transport you to the closest Medicare-participating, Joint Commission-accredited hospital with a copy of the Advance Directive if made available to us. More information regarding Advance Directives in Maryland is available at* http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289.
28. *To know that Advanced Surgery Center, LLC is owned by physicians, the physician who is performing your procedure may have a financial and ownership interest. Comfort Sedation, LLC provides Anesthesia to ASC and is owned by the same physicians. Patients are always free to choose any health care provider, subject to restrictions of their health insurance coverage. This disclosure is being made in accordance with Federal Regulations.*
29. *Please address any concerns about your referral to ASC with Ajay Bakhshi, M.D., Medical Director, Advanced Surgery Center, LLC.*
30. *If you feel that your rights have been violated in any way, please file a complaint with the Administrator or you may submit a written complaint to one of the addresses listed below.*
31. *To know how to contact your state agency and/or Medicare to voice a concern regarding any aspect of your care.*

AAAHC Institute for Quality Improvement : 5250 Old Orchard Rd. Suite 250 Skokie, IL 60077 Phone: (847) - 853-6060 Fax: (847) – 853-6118 www.aaahc.org/institute	State of Maryland: Office of Health Care Quality 7120 Samuel Morse Drive 2nd Floor Columbia, MD 21046 800-492-6005 www.ohcqweb@dhmh.state.md.us	Medicare: Medicare Ombudsman www.medicare.gov/ombudsman/resources.asp 1-800-633-4227

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the date of your procedure and have decided to have your procedure performed at this center.

Patient Name: _____

Signature of Patient or Patient Legal Representative: _____

Date: _____