CSC
CARRILLO SURGERY CENTER

PATIENT STICKER

PATIENT BILL OF RIGHTS

1. Patients have the right to be treated with consideration, respect, and dignity.
2. Patients have the right to be provided appropriate privacy.
3. Patient has the right to be provided personal privacy, receive care in a safe setting, and be free from all forms of abuse and harassment.
4. The patient has the right to the following:
    a. Be free from any act of discrimination or reprisal,
    b. Voice grievances regarding treatment or care that is (or fails to be) furnished, and
    c. Be fully informed about a treatment or procedure and the expected outcome before it is performed.
5. Patients are provided, to the degree known, information concerning their diagnosis, evaluation, treatment, and progress. When it is inadvisable to give such information to a patient, the information is provided to a person designated by the patient or a legally authorized person.
6. If a patient is adjudged incompetent under applicable state laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf.
7. If a state court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.
8. When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.
9. Patients have the right to actively participate in decisions regarding their healthcare, except when such participation is contraindicated for medical reasons.
10. Patients have the right to know about the facility services and provisions for after-hours and emergency care.
11. Patients have the right to examine and receive an explanation of their bill regardless of source of payment.
12. Patients have the right to being provided an estimate of fees for services and any payment policies prior to surgery.
13. Patient has the right to be informed of the facility's policy regarding advance directives/living wills. If an adverse event occurs during the treatment at this facility, resuscitative or stabilizing measures will be initiated before transferring the patient to another facility.
14. Patients have the right to know the credentials of healthcare professionals.
15. Patients have the right to know if there is an absence of malpractice coverage.
16. Patient has the right to express grievances/complaints and suggestions at any time and be informed of procedure to do so when requested. Expect the facility to establish a process for prompt resolution of patient grievances.
17. Patients have the right to expect personnel who care for them to be friendly, considerate, respectful and qualified through education and experience as well as perform the services for which they are responsible with the highest quality of care.
18. Patient has the right to exercise these rights without regard to gender, cultural, economic, educational, or religious background or the source of payment for his/her case.
19. Patients have the right to change primary or specialty physician or dentist if other qualified physicians or dentists are available.

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PATIENT RESPONSIBILITIES

1. Patients have the responsibility to provide accurate and complete information about his/her health, any medications, including over the counter products and dietary supplements, and any allergies or sensitivities.

2. Patients are responsible for following his/her provider's recommended treatment plan and participate in his/her care.

3. Patients are responsible for arranging for a responsible adult to take them home after surgery/procedure and remain with them at home for first 24 hours after surgery if required by his/her provider.

4. Patients are responsible for promptly fulfilling the financial obligations not covered by his/her insurance.

5. Patients are responsible for behaving respectfully toward all the health care professionals and staff, as well as other patients.

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Patient Registration Form

☐MED-PAY ☐MEDI-MEDI ☐MEDI-CAL ☐MEDICARE ☐PI LIEN ☐PPO ☐HMO ☐SELF-PAY ☐WC	
Patient's Name: FIRST LAST	Cell Phone: ( )
Address:	Work Phone: ( )
City: State: Zip Code:	Home Phone: ( )
Email:	
Sex: ☐ Male ☐ Female Date of Birth: MO / D / YR	Marital Status:
Social Security #:	Drive's License #:
Employer:	Occupation:
Emergency Contact Name:	Phone: ( )
Emergency Contact Address:	Cell Phone: ( )
Referring Physician:	Primary Language:
Person Responsible for Payment: ☐Self ☐Parent ☐Attorney (Name/Firm: _____) ☐Other (please specify: _____)	
Name of Insured:	Date of Birth: / /
Address:	Relationship to Patient:
Primary Insurance: Subscriber #:	Group #:
Workers' Comp Insurance Company:	Phone: ( )
Mailing Address:	Fax: ( )
Adjuster:	Employer at time of Injury:
Claim #:	Date of Injury: / /
Body Part Injured:	

FINANCIAL RESPONSIBILITY

I understand that I am responsible for payment for the *facility fee* which may be due at the time of service and/or thereafter (upon receipt of statement). I understand that the payment for *facility fee* does not include the professional/surgeon fees and fees for the anesthesiologist. If I have and provided insurance information, I understand, that as a courtesy Carrillo Surgery Center will bill my insurance carrier for services rendered and I understand that it is my responsibility to pay any balances NOT paid to the facility, Carrillo Surgery Center, by my insurance carrier. I have been informed that Carrillo Surgery Center may be an out-of-network ambulatory surgery center for some insurance plans and it is my responsibility to contact my insurance company in order to determine my benefits. I acknowledge that I am responsible to pay for any coinsurance, deductible, policy limitations or other cost shares as part of the Allowed Amount and/or charges not paid by or covered by my insurance. Should any payment be sent to me directly for the services rendered, I fully understand that I am responsible to assign/direct this payment to Carrillo Surgery Center right away. I understand that it is my responsibility to ensure all necessary authorizations are in place prior to my procedure, as needed.

ASSIGNMENT OF BENEFITS

I authorize the release of medical information necessary to process insurance claims from this office. I request and authorize assignment for payment of medical benefits to Carrillo Surgery Center.

RELEASE OF INFORMATION AND REQUEST FOR RECORDS

I authorize Carrillo Surgery Center to release information specific to my date(s) of service, and I authorize Carrillo Surgery Center to request and obtain copies of information contained in my medical records, including copies of reports, office notes, x-ray, MRIs, CT scans, and any other similar medical records as needed, from other healthcare/medical facilities.

_____ _____

Patient's Signature (or Patient Representative) **Date**

401 East Carrillo St., Suite A
Santa Barbara, CA 93101
P: 805-963-4785 F: 805-957-1067

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My Medication Record

Mi Registro de Medicamentos

LIST ALL MEDICATIONS AND MATERIALS YOU ARE ALLERGIC OR SENSITIVE TO:

INCLUDE HERBAL, OVER THE COUNTER DRUGS, SUPPLEMENTS & VACCINATIONS. ANY PRODUCT DESIGNATED BY THE FDA AS A DRUG. PLEASE INCLUDE ENVIRONMENTAL SENSITIVIES AS WELL.

Liste todos los medicamentos o cosas que te causan alergia incluyendo vitaminas, medicamentos naturales, venta sin recetas, vacunas, cualquier producto designado por la FDA como una droga y alergia ambientales.

ALLERGIES AND SENSITIVITIES / ALERGIAS Y SENSIBILIDADES

Medications/ Materials *Medicamentos/ Materiales*	**Type of Reaction** *Tipo de Reacción*

LIST THE MEDICATIONS YOU TAKE REGULARLY AND/OR AS NEEDED

INCLUDE HERBAL, OTC, & SUPPLEMENTS AS WELL.

Apunte los medicamentos que toma regularmente o ocasionalmente.
Incluyendo medicamentos en ventasin receta, medicamentos naturistas y vitaminas.

Medication Name *Nombre De Medicamento*	**What is it for?** *¿ Para Que?*	**Dose/ How Often?** *Dosis/ ¿Cada cuándo?*	**Date & time medication was last taken** ¿Fecha y hora que tomo la medicina por última vez?	**Doctor who prescribed it** *¿Recetado por que doctor?*

For more information on safe and effective medicine use ask your pharmacist or physician.

Para mára información sobre medicamentos seguros y efectivos pregúntele a su farmacia/ doctor.

*****BELOW TO BE COMPLETED BY PHYSICIAN*****

****Por debajo- debe ser completado por medico****

New Medications *Nuevo Medicamento*	**What is it for?** *¿ Para Que?*	**Dose** *Dosis*	**How Often?** *¿Cada cuando?*	**Date Started** *Fecha Comenzada*	**Time Started** *Hora Comenzada*

Medications being Discontinued *Medicamentos Discontinuada*	**Date Medication Discontinued** *Fecha cuando discontinuo medicamento*	**When to Resume** *Cuando Puedo Volver a Tomar*

_____ _____

Patient's Signature (Firma del Paciente) **Date** (Fecha)

_____ _____

Physician's Signature **Date**

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My Medication Record

Mi Registro de Medicamentos

Medication Name *Nombre De Medicamento*	**What is it for?** *¿ Para Que?*	**Dose/ How Often?** *Dosis/ ¿Cada cuándo?*	**Date & time medication was last taken** ¿Fecha y hora que tomo la medicina por última vez?	**Doctor who prescribed it** *¿Recetado por que doctor?*

_____ _____

Patient's Signature *(Firma del Paciente)* **Date** *(Fecha)*

_____ _____

Physician's Signature **Date**