



**Notice of Rights, Financial Disclosure, HIPAA & Advanced Directives**

**Notice of Rights**

Meridian Center For Surgical Excellence has established a Patient's Bill of Rights and Responsibilities, which is provided verbally and in writing in a language and manner the patient or patient's representative understands prior to the date of the procedure. Meridian Center For Surgical Excellence expects that observance of these rights will contribute to more effective patient care and greater satisfaction for patients, physicians and the facility.

**Financial Disclosure**

Meridian Center For Surgical Excellence is privately owned By Timothy Connall, M.D. and has informed the patient prior to the date of the procedure that their physician may have a proprietary interest in this facility. The patient has the right to choose the facility of his/her choice for health related services.

**HIPAA/ Patient Privacy**

HIPAA gives patients more control over, and knowledge about, who is using their medical information and for what purpose. Meridian Center For Surgical Excellence providers may share patient health information for treatment, billing, and health care operations. Reasonable efforts will be made to protect the privacy of your health information, whether it is maintained on paper or electronically, and regardless of how it is communicated.

**Advance Directives**

It is the policy of Meridian Center For Surgical Excellence regardless of any advance directives or instructions from a health care surrogate or power of attorney, that an unexpected medical emergency, which occurs during treatment at this facility, will be aggressively managed with resuscitative or other stabilizing measures followed by emergency transfer to the closest emergency room. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or health care power of attorney. Acknowledgement of this policy does not revoke or invalidate any current health care directive or health care power of attorney.

**Please check the appropriate box.** Have you executed an advance health care directive, a living will and/or a power of attorney that authorizes someone to make health care decisions for you?

- Yes**, I have an advance health care directive, living will and/or a power of attorney.
- I have provided my advance health care directive, living will and/or a power of attorney to Meridian Center For Surgical Excellence
- No**, I do not have an advance health care directive, living will and/or a power of attorney.
- I would like additional information on advance health care directives.

By signing this document, I acknowledge that all of the above information was given to me prior to my day of surgery, and that I have read and understand the information on patient rights, financial disclosure, HIPAA, and advance directives. I agree to the policies of Meridian Center For Surgical Excellence . If I have indicated I would like additional information, I acknowledge receipt of that information.

\_\_\_\_\_  
Patient Signature (If patient is unable to sign, please indicate relationship)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date