Tennessee Valley Eye Center
Advanced Surgery and Eye Care

160 Capital Drive
Knoxville, TN 37922
865.251.0338

Patient's Bill of Rights

As a patient of Tennessee Valley Eye Center, you have the right to receive the following information, in advance of the date of the procedure. Every patient has the right to be treated as an individual with his / her rights respected. The Facility and Medical Staff have adopted the following list of patient's rights:

- To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
- To be treated with respect, consideration, and dignity in receiving care, treatment, procedures, surgery and / or services.
- To be provided privacy and security of self and belongings during the delivery of patient care service.
- To receive information from your physician about your illness, your course of treatment and your prospects for recovery in terms that you can understand.
- To receive as much information about any proposed treatment or procedures as you may need in order to give informed consent prior to the start of any procedure or treatment. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- To make decisions regarding the care that is recommended by the physician. Accordingly, you may accept or refuse any recommended medical treatment. If treatment is refused, you have the right to be told what effect this may have on your health, and the reason shall be reported to the physician and documented in the medical record.
- To be free from mental and physical abuse, free from exploitation, and free from use of restraints. Drugs and other medications shall not be used for discipline of patients or for the convenience of facility personnel.
- Full consideration of privacy concerning your medical care program. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.
- Confidential treatment of all communications and records pertaining to your care and your stay in the facility. Your written permission shall be obtained before your medical records can be made available to anyone not directly concerned with your care. The facility shall establish policies to govern access and duplication of a patient's record.
- Leave the facility even against the advice of your physician.
- Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.
- Be informed by your physician or a delegate of your physician of the continuing health care requirements following your discharge from the facility.
- To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of your care
- Know which facility rules and policies apply to your conduct while a patient.

- Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on your behalf. All personnel shall observe these patient's rights.
- To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's usual care. Your written consent for participation in research shall be obtained and retained in your patient record.
- Examine and receive an explanation of your bill regardless of source of payment.
- To appropriate assessment and management of pain.

Advance Directives: You have the right to information on the Center's policy regarding Advance Directives. Advance Directives will not be honored within the Center. In the event of a life-threatening event, emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital, where the decision to continue or terminate emergency measures can be made by the physician and family. If the patient or patient's representative wants Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes.
We can provide state advance directive forms if requested**.**

Submission and Investigation of Grievances: You have the right to have your verbal or written grievances submitted, investigated, and to receive a written notice of our decision.
To file a grievance, you may contact the following individuals or agencies:

- TVEC Administrator – 160 Capital Drive, Knoxville, TN 37922 / Telephone: 865.251.0338
- Your State Representative
- TN Dept. of Health Division of Health Care Facilities, https://www.tn.gov/health/health-professionals/hcf-main/filing-a-complaint.html, or by mail to Division of HealthCare Facilities, Centralized Complaint Intake Unit, 665 Mainstream Drive, Second Floor, Nashville, TN 37243
- Medicare Ombudsman, https://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
- Medicare, www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)
- Office of the Inspector General, http://oig.hhs.gov

Physician Financial Interest and Ownership
The physician(s) performing procedures at this Center have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice.

Rights and Respect for Property and Person
The patient has the right to

- Exercise your right without being subjected to discrimination or reprisal.
- Voice grievance regarding treatment or care that is or fails to be furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.

Privacy and Safety
The patient has the right to

- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.

THE KNOXVILLE EYE SURGERY CENTER, LLC TENNESSEE VALLEY EYE CENTER
140 Capital Drive, Suite 2, Knoxville, Tennessee 37922

GENERAL CONSENT TO ADMISSION, MEDICAL TREATMENT AND RELEASE OF INFORMATION

CONSENT FOR TREATMENT: Authorization is hereby given to the Knoxville Eye Surgery Center, LLC to perform such treatments, services, procedures, diagnostic studies, nursing care, surgery, invasive procedures and medical treatment that my attending physician and/or his/her designee consider to be necessary. I understand that medicine is not an exact science and that diagnosis and treatment may involve risk of injury or even death. I acknowledge that no guarantees have been made to me regarding the outcome of this treatment. I understand that I have the right to accept or refuse consent of any proposed procedure or therapeutic course, and that I will not be involved in any research or experimental procedure without my knowledge and consent. Obtaining consent for special procedures and treatments is the responsibility of my physician.

ADVANCED DIRECTIVES: I understand that any Advanced Directive including a "Do Not Resuscitate" (DNR) order will be suspended while a patient at this ambulatory surgery center. All patients will be resuscitated and transferred to a hospital. I have the right to discuss this in advance with my surgeon if I do not wish to receive this emergency treatment in order to make special arrangements.

COPY PROVIDED BY PATIENT: ☐ YES ☐ NO

RELEASE OF INFORMATION: I authorize the Knoxville Eye Surgery Center, LLC and or my attending physicians to disclose any and all information in my medical record to any person, insurance company or other party which is or may be liable for all or part of the charges associated with this service. I further authorize the Knoxville Eye Surgery Center, LLC to furnish information contained in my medical record to other healthcare providers in order to facilitate my continued care and treatment. The Knoxville Eye Surgery Center, LLC is authorized to release this information even though the confidentiality of the information may be protected by Federal or State laws and regulations. The Knoxville Eye Surgery Center, LLC, its agents and employees, are hereby relieved of any liability that may arise from the release or reproduction of such records or information.

FINANCIAL AGREEMENT: For and in consideration of all services rendered by the Knoxville Eye Surgery Center, LLC I understand that I am responsible for the payment of any and all charges for services rendered which are not covered by Medicare, Medicaid, TennCare, private insurance or other third party payor. I accept responsibility for any services deemed medically unnecessary by any third party payor. I understand that if more than one person signs this agreement their liability shall be joining and several. If I or my insurance fail to make

payment for these services when due, the center may at any time, without notice or demand, declare the entire unpaid balance to be immediately due and payable. I further agree to pay reasonable attorney and collection fees if this account is placed for collection. I authorize and direct my insurance company to pay directly to Knoxville Eye Surgery Center, LLC any and all benefits up to the amount of my bill. I understand that all medical transportation costs, emergency room costs or hospital costs incurred due to medical necessity, physician services, including specifically services of radiologists, pathologists, and anesthesiologists, attending physicians and others will be billed independently by the provider of services and I accept responsibility for paying such charges and hereby grant assignment of insurance benefits for this service.

MEDICARE AND MEDICAID PATIENT CERTIFICATION/ INFORMATION: I certify that information given by me in application for payment under Title XVIII and Title XIX of the Social Security Act and Title XIX Medicaid is correct. I authorize any holder of information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I request payment of benefits be made on my behalf. I, as a Medicare beneficiary, have been informed in writing that the care for which Medicare payment is sought will be subject to review by the Peer Review Organization and some services may be denied as not medically necessary or appropriate. I am aware of my rights and responsibilities.

INFECTION CONTROL: If any employee of the Knoxville Eye Surgery Center, LLC or other health care worker is exposed to my blood or other body fluids, I hereby authorize the Knoxville Eye Surgery Center, LLC to test my blood for Hepatitis B & C and HIV (the virus that causes AIDS). I understand the tests will be done at the expense of the Knoxville Eye Surgery Center, LLC.

I HAVE READ THE ABOVE INFORMATION, AND I CERTIFY AND ACKNOWLEDGE THAT I UNDERSTAND ITS CONTENTS AND SIGNIFICANCE.

_____	_____	_____
Patient or Guardian	Relationship to patient	Date
_____	_____	
Witness	2nd Witness needed for verbal consent	

If patient is unable to execute above form for any reason, such as being a minor, explain: _____

KNOXVILLE EYE SURGERY CENTER, LLC
Tennessee Valley Eye Center
140 Capital Drive, Suite 2
Knoxville, TN 37922

HIPAA: Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand and have been provided with a Notice of Privacy Policy that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

We will need to use your information to contact you with appointment reminders; do we have your permission to:

Leave message on answering machine? ___ Yes ___ No

Leave message with family member? ___ Yes ___ No

I fully understand and ❑ **accept** ❑ **decline** the terms of this consent.

STATEMENT BILLING: I understand I may receive 3 separate statements (bills) for my surgery in the event the procedure is not completely covered by my insurance. Each billing office is separate.

- 1 statement from your surgeon
- 1 statement from Knoxville Eye Surgery Center
- 1 statement from your anesthesia provider

_____ _____

Patient's Signature Witness Signature

_____

Date

KNOXVILLE EYE SURGERY CENTER
160 CAPITAL DRIVE
KNOXVILLE, TN 37922

Patient ID: -
Alt. ID 1:
Gender: DOB:
Physician:

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Gender: F M **Date of Birth:** _____ **SS#:** _____

Billing Address: _____ **Apt. #:** _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Preferred Phone# Main: _____ **Work:** _____ **Cell:** _____

☐ **May we contact you by cell phone?**

Email: _____ **Marital Status: Please Circle: S M W D**

Employment Status (Circle): Retired / Disabled / Unemployed / Employed

Employer Name: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Who is the Responsible Party or Insurance Subscriber? **Patient** ☐ **Spouse** ☐ **Parent** ☐ **Other** ☐

If the Patient is NOT the Responsible Party or Insurance Subscriber, Please Complete the Following:

Last Name: _____ **First Name:** _____

Date of Birth: _____ **SSN#:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone#: _____ **Employment Status (Circle): Retired / Disabled / Unemployed / Employed**

Employer Name: _____

****Race and Ethnicity are required by the state of Tennessee****
Race (Circle): - White / Black or African American / Asian / Native American / Other

Ethnicity (Circle): - Not Hispanic / Hispanic / Hispanic Origin unknown

Emergency Contact (Not Living With You) **Name:** _____

Relationship to Patient: _____ **Phone:** _____

*** If you have Medicare Coverage, Please answer the following questions:**

Which of the following qualifies you for Medicare: ☐ **Age** ☐ **Disability** ☐ **End-Stage Renal Disease**

Do you have another insurance through your employer? ☐ **Yes** ☐ **No** **Or a spouse's employer?** ☐ **Yes** ☐ **No**

Are you receiving black lung benefits? ☐ **Yes** ☐ **No**

Is this treatment related to an accident? ☐ **Yes** ☐ **No** **If yes, what type of accident:** ☐ **Auto** ☐ **Work** ☐ **Other**

Is treatment covered under the VA? ☐ **Yes** ☐ **No**

Is treatment due to the fault of another? ☐ **Yes** ☐ **No**

Form completed by: _____ _____
Signature/Relationship to Patient **Date**

Patient's transportation home: _____
Name/Phone# (If this is a transportation service PLEASE notify the receptionist)

To pay online visit www.tveyecenter.com