Miranda Reed, DO
Colin Kress, DO

CLEAVER MEDICAL GROUP
SURGERY CENTER

105 Professional Park Drive Suite 200
Cumming, GA 30040

Phone: 770.800.3455
Fax: 770.284.8380

www.cleavermedicalgroup.com

For surgeries scheduled at Cleaver Medical Group Surgery Center:

Our billing department will be contacting you and will provide you with an **ESTIMATED** cost analysis for PHYSICIAN AND FACILITY fees. Until your claim is processed, an exact patient financial liability is not known. Therefore, the cost analysis our office provides is only an **ESTIMATE**. Patients will be financially responsible for any deductible, co-insurance and/or co-pay amounts assessed by the insurance company regardless of the estimated cost provided prior to surgery.

Anesthesia services are not included in estimates provided by our office and will be billed separately by MRC Anesthesia. Payments can be made over the phone by calling the billing department directly at 770.746.6424.

Anesthesia, imaging, pre-op labs, and all lab fees are not included in estimates provided by our office and will be billed separately by the facility providing the service. **Any questions regarding bills for these services, should be directed to the facility providing the service.**

Depending on the global period for the surgical procedures performed, post-operative visits may NOT be included in surgical fees and the patient will be responsible for any deductible, co-insurance and/or co-pay amounts assessed by the insurance company.

CLEAVER MEDICAL GROUP SURGERY CENTER INSTRUCTIONS

You will need to have a pre-op interview, prior to surgery. **The interview will take approximately 15 minutes**. When you come in for your pre-op or are called for a phone interview, please have available a list of **ALL** medications that you are currently taking. We will need the name and the dosage information. This includes any vitamins, herbal supplements, diet pills or over the counter medications. The nurse will ask some questions, go over your medical history, and give pre-operative instructions to follow on the morning of your procedure. You will receive a phone call 3 - 5 days prior to your procedure with the exact arrival time.

PLEASE FOLLOW THE FOLLOWING INSTRUCTIONS TO ENSURE YOUR SAFETY AND COMFORT BEFORE THE PROCEDURE.

1. Call your doctor if you develop any signs or symptoms of illness before your scheduled procedure.
2. **DO NOT** smoke, drink alcohol or chew tobacco after midnight the night before the procedure.
3. **DO NOT** take Aspirin or Aspirin products (Goody's powder, Excedrin, etc.) for 7-10 days prior to surgery.
4. **DO NOT** take NSAIDS such as Ibuprofen, Motrin, Advil, Aleve, Naproxen, etc. for 3 days prior to surgery.
5. **TELL** your doctor if you are on any blood thinners, such as Plavix, Coumadin, Brilanta, Xarelto, Warfarin, Eliquis, etc.
6. **DO NOT** take any blood thinning supplements such as fish oil, Vitamin E, Tumeric, Gingko Biloba, Cinnamon, Garlic, Saw Palmetto, etc. for 7-10 days prior to surgery.

If your surgery requires sedation the following instructions apply:

7. **DO NOT** eat or drink anything after midnight the night before the procedure.
   YOU MAY TAKE medication early in the morning the day of the procedure with a sip of water **ONLY IF INSTRUCTED** to do so by your pre-op nurse.
   YOU MAY HAVE clear liquids **ONLY** (i.e. Sprite, apple juice, water, Gatorade) after midnight the night before the procedure up until 2 hours prior to the arrival time of the procedure. _____
8. You should have **NOTHING** to eat or drink for 2 hours prior to arrival time.

DAY OF PROCEDURE:

1. Take your medication with a clear liquid the morning of the procedure if directed to do so by the nurse.
2. Arrange to have an adult drive you home **AFTER** the procedure. (if you received sedation).
3. Take a bath or shower.
4. Wear loose fitting, comfortable clothing. No metal anywhere on your body or clothing.
5. Remove contact lens, nail polish, hair pins, hair pieces and makeup before arriving at the surgery center.
6. **DO NOT** bring any jewelry or valuables with you to the surgery center.
7. **DO NOT** bring small children to the surgery center the day of the surgery.
8. Due to limited seating in the waiting area, please limit guests to 1 per patient.

PLEASE NOTE:

1. Failure to follow these instructions or late arrival for your appointment may result in cancellation or delay of the procedure.
2. If you should have any questions or are unable to get to Cleaver Medical Group Surgery Center the day of the surgery, please call **770.800.3455** before the time you are scheduled to arrive.

I authorize CMG ASC to leave messages regarding my procedure at this phone number: _____
Yes No

Patient/Guardian Signature: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____ Time: _____

CLEAVER MEDICAL GROUP SURGERY CENTER INSTRUCTIONS

PATIENT RIGHTS

The patient has the right to:

1. become informed of his/her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may have a family member or representative of his/her choice be involved in his/her care.
2. exercise these rights without regard to race, sex, cultural, educational, or religious background or the source of payment for care.
3. be treated with respect, consideration, and dignity in a safe environment free from all forms of abuse or harassment.
4. remain free from seclusion or restraints of any form that are not medically necessary.
5. coordinate his/her care with physicians and healthcare providers and be provided, to the degree known, complete information concerning their diagnosis, evaluation, prognosis and any proposed treatment or procedures as needed to give informed consent or to refuse treatment. This information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment, non-treatment and the risks involved.
6. full consideration of patient privacy concerning consultation, examination, treatment, and surgery.
7. confidential treatment of all communications, disclosures and records pertaining to patient care; patients will be given the opportunity to approve or refuse their release except when release is required by law. Patient will have access to information in the medical record within reasonable time frame (48 hours).
8. leave the facility even against medical advice.
9. be informed about procedures for expressing suggestions, complaints and grievances including those required by state and federal regulations.
10. be informed by physician or designee to the continuing healthcare requirements after discharge.
11. examine and receive an explanation of the bill regardless of source of payment.
12. have all patient's rights apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.
13. interpretive services if needed.
14. be informed regarding patient conduct and responsibilities, services available at the surgery center, provisions for after-hours and emergency care, fees for services, payment policies, right to refuse participation in experimental research, charity and indigent care policy, charges for services not covered by third-party payors, and credentials of health care professionals.

PATIENT RESPONSIBILITIES

The patient has the responsibility to:

1. provide complete and accurate information concerning present complaints, past illnesses, hospitalizations, other health issues, all medications.
2. make it known whether the planned surgical procedure/treatment risks, benefits and alternative treatments have been explained and understood.
3. follow the treatment plan established by the physician, including instructions by nurses and other health care professionals, given by the physician.
4. keep appointments or notify the facility in advance if unable to do so.
5. accept full responsibility for deciding to refuse treatment and/or not follow directions.
6. fulfill the financial obligations of his/her care as promptly as possible.
7. be respectful of all the health care providers and staff, as well as other patients in the facility and follow facility policies and procedures.
8. notify the staff if they have any safety concerns or feel their privacy is being violated.
9. provide a responsible adult to transport him/her from the surgery center and remain with him/her for 24 hours, if required by his/her provider.
10. inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

PATIENT COMPLAINTS

Patients have the right to register a complaint, in writing, to the Administrator of Cleaver Medical Group Surgery Center. Please submit complaint to:

ATTN: Ashley Dorsey
Cleaver Medical Group Surgery Center
105 Professional Park Drive Suite 200
Cumming, GA 30040

If the complaint is not resolved to the patient's satisfaction, he/she has a right to file a grievance with the Healthcare Facility Regulation Division, Department of Community Health, Complaints Unit or Accreditation Association for Ambulatory Health Care (AAAHC) for concerns against the surgery center, the Georgia Composite Medical Board concerning the physician or the Professional Licensing Boards Division, Georgia Board of Nursing with concerns against any of the nursing staff. The patient should provide the physician or surgery center name, and address and the specific nature of the complaint.

COMPLAINTS AGAINST THE ASC:

Healthcare Facility Regulation Division
Department of Community Health
Attn: Complaints Unit
2 Peachtree Street, N.W., Suite 31-447
Atlanta, Georgia 30303-3142

P: (404) 657-5700
F: (404) 657-5731

ONLINE:
https://dch.georgia.gov/divisionsoffices/healthcare-facility-regulation/facility-licensure/hfr-file-complaint

AAAHC
5250 Old Orchard Road, Suite 200
Skokie, Illinois 60077

P: (847) 853-6060
F: (847) 853-9028

E-mail: info@AAAHC.org

COMPLAINTS AGAINST THE PHYSICIAN:

Georgia Composite Medical Board
Enforcement Unit
2 Peachtree Street, N.W., 36th Floor
Atlanta, Georgia 30303

P: (404) 657-6494
F: (404) 656-9723

ONLINE:
https://gcmb.mylicense.com/verification/Search.aspx?SubmitComplaint=Y

COMPLAINTS AGAINST NURSING STAFF:

Professional Licensing Boards Division
Georgia Board of Nursing
237 Coliseum Drive
Macon, Georgia 31217-3858

P: (478) 207-2440

ONLINE:
http://verify.sos.ga.gov/verification/Search.aspx?SubmitComplaint=Y

ISSUES REGARDING MEDICARE:
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
or call 1-800-633-4227

I verify I have received and understand the information regarding Patient Rights and Responsibilities, Patient Privacy and Grievance Procedures.

_____	_____	_____
Patient/Guardian Signature	Relationship to Patient	Date/Time

Cleaver Medical Group Surgery Center

Notice of Privacy Practices
Effective May 2021

HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the facility may be billed to and payment may be collected from you, an insurance company or a third party.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are involved in taking care of you at the facility or the hospital.

For Health Care Operations. We may use and disclose medical information about you for health care operations such as quality improvement efforts. These uses and disclosures are necessary to run the facility and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other facility personnel for review and education purposes.

WHO WILL FOLLOW THIS NOTICE Any health care professional authorized to enter information into your medical chart including all facility doctors, nurses and personnel will abide by this notice.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the facility. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel or by your doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for public health-related benefits and services; to individuals involved in your care or payment for your care; research; and to avert a serious threat to health or safety. Other uses and disclosures of your personal information could include disclosure to, or for: medical examiners; law enforcement; lawsuits and disputes; military and veterans; national security; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" listing the disclosures we have made of medical information about you.

Right to Amend. If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the Administrator, and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care.

Right to a Paper Copy of this Notice. You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way. You must make your request in writing, and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Administrator.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint. ***You will not be penalized for filing a complaint.***

COMPLAINTS AGAINST THE ASC:

Healthcare Facility Regulation Division
Department of Community Health
Attn: Complaints Unit
2 Peachtree Street, N.W., Suite 31-447
Atlanta, Georgia 30303-3142

P: (404) 657-5700
F: (404) 657-5731

ONLINE:
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COMPLAINTS AGAINST NURSING STAFF:

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P: (478) 207-2440

ONLINE:
http://verify.sos.ga.gov/verification/Search.aspx?SubmitComplaint=Y

ISSUES REGARDING MEDICARE:
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

CHANGES TO THIS NOTICE. We reserve the right to change this notice. A copy of the current notice will be posted in the waiting room.

If you have any questions about this notice or need further information, please contact: Ashley Dorsey, Administrator at (770)746.6380.

CLEAVER MEDICAL GROUP SURGERY CENTER

CONSENT AND TREATMENT AUTHORIZATION

I hereby consent to the rendering of such care and treatment as the physicians and medical staff of Cleaver Medical Group Surgery Center consider to be necessary and appropriate. The consent to receive medical treatment includes, but is not limited to, examinations, diagnostic and therapeutic procedures, medications, anesthesia, and any other medical treatment and services which I may require. I hereby acknowledge that the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may involve risk of injury and of adverse results. I hereby acknowledge that no guarantees have been made to me as to the results of the procedures, which I may undergo while a patient of Cleaver Medical Group Surgery Center.

ACKNOWLEDGEMENT OF PATIENT

I understand that:

- **a)** my physician or Cleaver Medical Group Surgery Center may permit one or more observers to be present during my surgery for educational, accreditation or licensing purposes. Photography of my surgery may occur at my physician's discretion.
- **b)** I should not drive until the effects of any medication received have worn off. I must have a responsible adult drive me home if I received sedation.
- **c)** the Cleaver Medical Group Surgery Center is not responsible for the loss of or damage to any article of value brought to the facility.
- **d)** because of the possible adverse effects of some medications on an unborn fetus, it is important to know if I am pregnant. Therefore, I certify that to the best of my knowledge, I am NOT pregnant.

ADVANCE DIRECTIVES

Cleaver Medical Group Surgery Center will ask me if I have executed an advance directive. I am aware that Cleaver Medical Group Surgery Center typically treats healthy patients undergoing elective procedures. Therefore, the extent to which my Advance Directive specifies may be limited. I consent to resuscitative measures as deemed necessary by my physician in the event of a life-threatening emergency. I consent to emergency transfer to Northside Forsyth Hospital in case of the need for emergency hospital care. A copy of my Advance Directive, if provided, will be placed on my chart, and transferred to the hospital in the event of a transfer. Information regarding Advance Directive has been made available to me preoperatively. Northside Forsyth Hospital is not affiliated or in partnership with Cleaver Medical Group Surgery Center.

OWNERSHIP

I understand that Cleaver Medical Group Surgery Center is owned by Miranda Reed, DO (100%). I have been given the option of having my surgery at a facility not owned by physicians and choose to have my surgery at Cleaver Medical Group Surgery Center.

GRIEVANCE PROCEDURE

All alleged grievances will be fully documented, investigated, and reported to the Administrator of Cleaver Medical Group Surgery Center. Any substantiated allegation will be reported to the State and/or local authority. The grievance documentation will include the process for how the grievance was addressed. The patient will be provided a thorough written notice of the decision, within (20) days of receipt of the grievance. The contact information for the State of Georgia is included on the Patient Bill of Rights that I received. The patient will be advised of the grievance status throughout the process.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the request and/or release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary for processing insurance claims, utilization review, quality assurance activities or continuity of care. This authorization applies to all healthcare providers involved in my treatment at the facility.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I hereby assign to Cleaver Medical Group Surgery Center all surgical, medical insurance and/or other benefits for services rendered by Cleaver Medical Group Surgery Center. It is the policy of Cleaver Medical Group Surgery Center to collect payment at the time of service. Cleaver Medical Group Surgery Center will file a claim to my insurance. I am aware that any charges NOT COVERED by my insurance policy, including co-insurance and deductible, are my responsibility. I understand that my insurance company may send payments for the rendered services to me. I agree to endorse the insurance check(s) over to Cleaver Medical Group Surgery Center. I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud.

I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME AND UNDERSTAND THE CONTENTS OF THIS DOCUMENT.

Patient/Guardian Signature:_____ Relationship to Patient:_____

Witness Signature: _____ Date: _____Time: _____

Patient Name: _____ Rev. 2021