507 N Sullivan Rd, Suite 120, Spokane Valley, WA 99037

602 N Calgary Ct, Suite 202, Post Falls, ID 83854

Liberty Oral & Facial Surgery

P: (509) 922-2273
F: (509) 344-1113
info@libertysurgerycenter.com

https://libertyoralsurgery.com/

Patient Rights and Responsibilities

Patient Rights:

- *Respect and Dignity:* You have the right to be treated with consideration, respect and dignity, acknowledging your individuality and the values that affect your response to care.
- *Privacy:* You have the right to expect that all of those involved in your care will honor your right to privacy and ensure the privacy of your care and medical record.
- *Identity:* You have the right to know the names, positions and professional relationships of all individuals involved in your care.
- *Information:* You have the right to expect to receive sufficient information, in terms you understand, regarding your diagnosis, treatment prognosis, and follow-up care (*In the event that your health makes it inadvisable to give you such information, the information will be provided to a person designated by you or a legally authorized person)*.
- *Interpretation:* We will schedule an interpreter upon your request that may be billed through your insurance.
- *Participate in Care Decisions:* You have the right to participate in the decisions affecting your healthcare in collaboration with your physician/surgeon, except when such participation is not indicated for medical reasons.
- *Change Care Providers:* You have the right to change your provider if other qualified providers are available.
- *Refuse Treatment:* You have the right to accept medical care or refuse treatment, within the limits of the law, and to be informed of the consequences of refusal.
- *Assessment of Pain:* You have the right to appropriate assessment and management of pain.
- *Access to Medical Record:* You have the right to inspect and obtain a copy of your medical record (in a variety of formats), and to expect a reasonable and timely transfer of information from one physician to another.
- *Knowledge of Financial Obligations:* You have the right to information regarding your bill prior to treatment, and to examine and receive an explanation of your bill regardless of the source of payment.
- *Resolution of Patient Complaints:* You have the right to expect that Dr. Bryan McLelland will try to resolve all patient complaints without compromising your future access to care. If you have a complaint, please request a patient grievance form from the front desk.

- *Advanced Directives:* You have the right to have an Advanced Directive. However, Dr. Bryan McLelland does not honor Advanced Directives. If you have any questions about this policy, please ask your physician/surgeon for more information.
- *Telehealth/Telemedicine:* You have the right to the same standard of care of providing informed consent, privacy to your medical information, and any other duties associated with practicing medicine regardless of whether your appointment is in-person or a telehealth visit.

Patient Responsibilities:

Providing Information: You are responsible for providing, to the best of your knowledge, accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health. You are responsible for reporting any perceived risks regarding your care and unexpected changes in your condition *Asking Questions:* You are responsible for making known whether you clearly comprehend your diagnosis, treatment, and follow up care plan, and what is expected of you.

- *Participation:* You are responsible to fully participate in decisions involving your health care and to accept the consequences of those decisions if complications occur.
- *Following Instructions:* You are responsible for following the treatment plan recommended by your physician/surgeon. You should express your concerns regarding your inability to comply with a planned course of treatment, and in understanding the consequences of any treatment alternatives.

Accepting Consequences: You are responsible for your actions if you refuse treatment, or do not follow the physician/surgeon's instructions.

Following Rules & Regulations: You are responsible for keeping your appointment, or cancelling 24 hours prior to your scheduled appointment. You are also responsible for helping to control noise and disturbances, following the no smoking policy and respecting the property of others.

- *Meeting Financial Commitments:* You are responsible for assuring that the financial obligations for your health care are fulfilled as promptly as possible.
- *Respect and Consideration:* You are responsible for being considerate and respectful of the rights of others.
- *Telehealth/Telemedicine:* Your responsibilities remain the same whether your appointment is in-person or telehealth. Additionally, you are responsible for your telehealth environment including ensuring your privacy and safety.

You are a partner in the health care process! Your involvement in helping us deliver quality health care is important. Please share your

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concerns and comments with us. Should you have a complaint, we would appreciate it if you would bring it to the attention of our senior management team by requesting a grievance form. You have the right to expect that Dr. Bryan McLelland will try to resolve all of your concerns without compromising your future access to care. If you have any questions or concerns regarding your care in this facility, please feel free to contact us.

I acknowledge that I have received a copy of the Patient Rights and Responsibilities for the offices of Liberty Surgery Center. Dr. Bryan McLelland reserves the right to change the practices that are described in this document. If practices change, I will be offered a copy of the revised Patient Rights and Responsibilities at the time of my first visit after the revisions become effective. I may also obtain a revised copy by requesting that one be mailed to me.

Patient/Legal Representative Signature:

_____

Date: _____

MR#: _____

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Financial Policy

We share your concerns regarding the increasing cost of health care. We believe that you, our patients, expect and deserve the highest quality care we can provide at a reasonable cost. While we take advantage of every possible avenue to keep costs down, we are committed to not sacrificing quality for less expensive care. With this in mind, we would like to share some information with you about our financial policy. Many people are under the impression that if they have insurance, it is the insurance company who owes the doctors for their services. Please keep in mind the insurance contract is between the patient and the insurance company. Therefore, **the patient is responsible for the bill, regardless of insurance coverage determination**. As a courtesy to our patients, we are happy to bill your dental insurance for you and, if possible, will also bill your medical insurance; however the responsibility for payment remains with the patient (or insured). If you have additional coverage, we will assist you in billing your secondary policy. **At the time of treatment, patients are requested to pay their estimated portion of the charges.** Patient portions that are due at the time of service are an estimation, the exact amount cannot be determined until the insurance company has paid. Many insurance plans state that you will be covered up to “50%, 80% or 100%”. In spite of that statement, we have found in actuality that many plans may cover less than that depending upon their established “usual and customary” fees, and what services they actually cover. Insurance companies use the terms “usual and customary” when setting fee limitations on services. Please be aware that some insurance companies will pay a claim percentage based on their “usual and customary” fees, not our actual charges. If there is an overpayment on your account, a refund check will be sent to your address.

After receiving the estimated patient portion and insurance payment, any remaining balance must be paid within 60 days. In the event that payment for our services is not made within 60 days of receipt of services, an interest charge of 1% per month may be added to the account, (12% per annum). Therefore, patients with insurance whose claims have not been paid within 45 days should contact their insurance company to determine the reason for delay of payment. Delinquent accounts will be referred for collection.

Payment Options: Checks, Cash, Visa or Master Card may be used for payment on your account. There will be a $25.00 charge for all returned checks. The practice also offers other payment options such as Care Credit. Please ask your financial coordinator about these options.

Hospital Surgery: We require pre-authorization for all hospital surgery. Financial arrangements for hospital and ASC surgeries are made on an individual basis with our financial coordinator prior to scheduling surgery, and patient portions are due one week prior to the scheduled surgery.

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Assignment and Release: For individuals with insurance, your signature below hereby authorizes your insurance benefits to be paid directly to Liberty Surgery Center. You are still financially responsible for any balance due after insurance payments. It also authorizes the doctor to release any information required for payment and processing of this claim. If an insurance payment is sent to you, it must be forwarded to our office promptly.

Implant Policy: Dental implants have a high survival rate. Dental implants can last for many, many years for one patient and may last a shorter period of time for another. Dental implants are a medical device and it must be remembered that medical devices can fail. Some factors that can influence the life/or longevity of a dental implant are: a patient's medical history, smoking status, periodontal disease, clenching, grinding, and general oral hygiene practices. Another important thing to remember is that our own teeth don't last a lifetime, so it is a safe assumption that a dental implant(s) won't either. With this said, Liberty Surgery Center will replace a failed implant up to two years following the original date of placement at no cost to you (the patient). If a dental implant fails after two years, the replacement costs are the patient's responsibility

Patient/Legal Representative Signature:

_____

Date: _____

MR#: _____

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Acknowledgement of Notice of Privacy Practices

I acknowledge that I have access to the Notice of Privacy Practices for the office of Liberty Surgery Center. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is posted in the facility, on the website, and is available for patient review.

Date: _____

Signature: _____

Printed: _____

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ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY ____Yes _____ No
SPOUSE ONLY ____Yes _____ No
OTHER (*PLEASE SPECIFY*) _____Yes _____ No
Name: _____ DOB: _____

Name of Patient:
MR#:

_____
Patient/Legal Representative signature

Date: _____

(*Include Description of Personal Representative Authority)*

OFFICIAL USE ONLY BELOW THIS LINE

Record of Acknowledgement Not Obtained/Accepted

PROVIDED PRIOR TO TREATMENT? _____Yes _____No
DATE PROVIDED: _____
REASON FOR DENIAL:
_____ NEEDED MORE TIME TO REVIEW NOTICE OF PRIVACY PRACTICES.
_____ WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.
_____ UNABLE TO SIGN.
_____ REASON NOT GIVEN.
_____ OTHER (EXPLAIN):