

Surgery Center of the Lakelands

PATIENTS' BILL OF RIGHTS

The **PATIENT** has the right to be treated with consideration, respect, and dignity, without coercion, discrimination, or retaliation, and regardless of race, religion, sex, sexual orientation, ethnicity, age, or handicap.

The **PATIENT** or the **PATIENT REPRESENTATIVE** or **SURROGATE** has the right to all complete and current information concerning their diagnosis, evaluation, treatment, and prognosis, in terms, in a language, and/or in a manner that he/she can understand. If not medically advisable to give information to the patient, the information shall be made available to another designated, appropriate person in their behalf.

The **PATIENT** has the right to know the person or persons responsible for coordinating their care and their credentials.

The **PATIENT** has the right to receive from the physician enough information to understand the services being rendered in order to sign the informed consent and make decisions concerning medical care.

The **PATIENT** has the right to refuse treatment and to be informed of possible consequences of his/her actions and to be informed of his/her right to change physicians if another qualified physician is available.

The **PATIENT** has the right to privacy of information concerning his/her medical care or treatment and to appropriate physical privacy.

The **PATIENT** has the right to be informed of any persons other than routine personnel that would be observing or participating in his/her treatment and to refuse that observation and/or participation.

The **PATIENT** has the right for all medical records to be treated as confidential and given the opportunity to approve or refuse their release except when required by law and /or unless it would cause a negative outcome in the continuation of medical care.

The **PATIENT** has the right to information concerning the facility to which he/she may have to be transferred if possible and the reason for transfer. The facility that the patient is to be transferred to must give approval prior to the patient transfer.

The **PATIENT** has the right to know if any research will be done during his/her treatment and has the right to refuse it.

The **PATIENT** has the right to expect quality, safe care and service from *SURGERY CENTER OF THE LAKELANDS*.

The **PATIENT** has the right to have pain treated as effectively as possible.

The **PATIENT** has the right to be free from unnecessary use of physical or chemical restraint or seclusion as a means of coercion, convenience or retaliation and to be free from mental and physical abuse, harassment and/or exploitation.

The **PATIENT** has the right to be informed of the mechanism by which he/she will have continuing health care following discharge from *SURGERY CENTER OF THE LAKELANDS*.

The **PATIENT** has the right to know, in advance, the expected amount of his/her bill, and the right to examine and receive an explanation of their bill, regardless of the source of the payment and to know the source of payment of their bill.

The **PATIENT** has the right to know, in advance, if their physician has ownership in *SURGERY CENTER OF THE LAKELANDS*.

The **PATIENT** has the right to know what *SURGERY CENTER OF THE LAKELANDS* Patient Responsibilities apply to his/her conduct as a patient.

The **PATIENT** has the right to receive information about Advance Directives and to know that because surgery performed in the center is not likely to be "high-risk" or on patients who are not deemed to be appropriate candidates for outpatient procedures, our policy is to resuscitate and stabilize patients and transfer them to a hospital where their Advance Directives will be carried out.

The **PATIENT** has a right to express a grievance as required by law and to make suggestions to the facility. Grievances will be addressed immediately and resolved as soon as feasibly possible but no more than 30 days. Patient, Patient Representative, or Patient Surrogate will be contacted in writing of the Center's decision.

Please utilize our suggestion box in the lobby or speak with Valarie Price, BSN,RN, Director.

Telephone: 864-725-7520

To file a grievance with the state of South Carolina, please visit:
<https://apps.dhec.sc.gov/Health/HRComplaints/DefaultComplaintPublic.aspx>

or write to:
SC DPH Health Licensing
2600 Bull Street
Columbia SC 29201
(803)545-4370
Or

<https://www.AAAHC.org>

or write to:
Accreditation Association for Ambulatory Health Care
3 Parkway North, Suite 201
Deerfield, IL 60015
(847)853-6060

For Medicare Beneficiaries: the role of the Medicare Beneficiary Ombudsman is to ensure that Medicare beneficiaries receive the information and help they need to understand their Medicare options and to apply their Medicare rights and protections.
Web site: <http://www.cms.hhs.gov/ombudsman/resources.asp>

Surgery Center of the Lakelands PATIENTS' RESPONSIBILITIES

It is the **PATIENT'S** responsibility to read and understand all permits and/or consents to be signed: Ask either the nurse or physician to clarify any information not understood about care or services.

It is the **PATIENT'S** responsibility to notify *SURGERY CENTER OF THE LAKELANDS* if they need assistance of an interpreter to read and understand what is going to happen to them, sign documents or if they have designated a **PATIENT REPRESENTATIVE** or **SURROGATE** to assist with their intervention.

It is the **PATIENT'S** responsibility to answer all medical questions truthfully, to the best of their knowledge including complete information about symptoms, past illnesses, medications, including over-the-counter products, herbal supplements, any allergies or sensitivities, and other matters relating to plan of care.

It is the **PATIENT'S** responsibility to follow the pre-operative instructions given by the physician and/or *SURGERY CENTER OF THE LAKELANDS*.

It is the **PATIENT'S** responsibility to notify *SURGERY CENTER OF THE LAKELANDS* on admission if pre-operative instructions have not been followed.

It is the **PATIENT'S** responsibility to provide transportation to and from *SURGERY CENTER OF THE LAKELANDS* as appropriate and according to preoperative instructions and to provide for assistance with care for 24 hours after surgery as required by his/her provider.

It is the **PATIENT'S** responsibility to follow the post-operative instructions given by the physician(s) and/or nurses, including instructions regarding post-operative appointments.

It is the **PATIENT'S** responsibility to contact the physician if any complications occur.

It is the **PATIENT'S** responsibility for their own actions if treatment is refused or pre- or post-operative instructions are not followed.

It is the **PATIENT'S** responsibility to assure all payments for service rendered are on a timely basis and ultimate responsibility is the patients', regardless of insurance coverage.

It is the **PATIENT'S** responsibility to provide financial and/or insurance information regarding who will be responsible for the bill including current address and authorized contact information.

It is the **PATIENT'S** responsibility to notify the administration of *SURGERY CENTER OF THE LAKELANDS*, if the **PATIENT** or the **PATIENT REPRESENTATIVE** or **SURROGATE** thinks their right(s) have been violated or if the **PATIENT** has a significant complaint.

It is the **PATIENT'S** responsibility to provide *SURGERY CENTER OF THE LAKELANDS* with information about their Advance Directive decisions if they have made any, and provide a copy if possible.

It is the **PATIENT'S** responsibility and those accompanying the PATIENT to respect the rights and privacy of other patients and *SURGERY CENTER OF THE LAKELANDS* personnel and follow the Center's policies and PATIENT RESPONSIBILITIES.

Please utilize our suggestion box in the lobby or speak with Valarie Price, RN, BSN, MBA, Administrator.
Telephone: 864-725-7520

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www.scdhec.gov/health/licen/complaint.htm or

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