Newhall Oral and Maxillofacial Surgery Group

Alexei Mizin, DMD, Gennady Landa, DMD, MD,
John Scaramella, DDS, and Andrei Marechek, MD, DDS

PATIENT ADVANCE NOTIFICATION/ DISCLOSURE OF OWNERSHIP

DISCLOSURE OF OWNERSHIP

This facility is owned by Alexei Mizin, DMD, Gennady Landa, DMD, MD, John Scaramella, DDS, and Andrei Marechek, MD, DDS

PATIENT RIGHTS

Patient has the right to be informed of his or her rights in advance of receiving care. The patient may appoint a representative to receive this information should he or she desire.

PATIENTS HAVE THE RIGHT TO

- Exercise these rights without regard to sex, culture, economic, educational or religious background, or the source of payment of care.
- Considerate, respectful, and dignified care, provided in a safe environment, free of all forms of abuse, neglect, harassment and or exploitation.
- Access protective and advocacy services or have the services assessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Knowledge of Alexei Mizin, DMD, Gennady Landa, DMD, MD, John Scaramella, DDS, and Andrei Marechek, MD, DDS who has primary responsibility for coordinating his or her care and the names of professional relationships of other physicians and healthcare providers who will see them. The patient has the right to change providers if other qualified providers are available.
- Be advised if the position has a financial interest in the surgery center.
- Receive complete information from his or her position about his or her illness, course of treatment, alternate treatments, outcomes of care including unanticipated outcomes, and prospects for recovery in terms he or she can understand.
- Receive as much information about any proposed treatment or procedure as he or she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risk involved in treatment, alternate courses of treatment or non-treatment and the wrist involved in each and the name of the person who would carry out the procedure or treatment.
- Participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his or her medical care. To the extent permitted by law, this includes the right to request and or refuse treatment.
- Be informed of the facility's policy and state regulations regarding advance directives and be provided advance directive forms if requested.
- Full consideration of privacy concerning his or her medical care. taste discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.
- Confidential treatment of all communications and records were tending to his or her care and his or her stay at the facility. His or her written permission will be obtained before medical records can be made available to anyone not directly concerned with their care.
- Received information in the manner he or she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and as appropriate, the language of the patient. As appropriate, communication specific to the vision, speech, hearing, cognitive, or language impaired patient will be appropriate to the impairment.
- Access information contained in his or her medical record with a reasonable time frame.
- Be advised of the facility's grievance process, should he or she wish to communicate a concern regarding the quality of care they received. Notification of the grievance process includes whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of

the facilities contact person, the steps taken on his or her behalf to investigate the grievance, the results of the agreements and the grievance completion date.

- Be advised of the contact information for the state agency to which complaints can be reported, as well as the contact information of the office of the Medicare Beneficiary Ombudsman.
- Full support respect of all patient rights should the patient choose to participate in research, investigation, and or clinical trials. This inclusive includes the patient's right to a full informed consent process as it relates to the research, investigation, and your clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent forms.
- Examine and receive an explanation of his or her bill regardless of source of payment. You paragraph know which facility rules and policies apply to his or her contact while a patient.
- Have all patients' rights apply to the person who may have a legal responsibility to make decisions regarding Medical Care on behalf of the patient.

PATIENT ADVANCE NOTIFICATION DISCLOSURE OF OWNERSHIP PART 2

PATIENT RESPONSIBILITIES

The patient has the responsibility to provide accurate and complete information concerning his or her present complaints, past illnesses, hospitalizations, medications including over-the-counter products and dietary supplements, allergies and sensitivities, and other matters relating to his or her help.

- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- Patient responsible for following the treatment plan to satisfy his or her position, including the instructions of nurses and other Healthcare professionals as they carry out the physician's orders.
- The patient is responsible for his or her own actions should treatment be refused or a physician's orders are not followed.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible for informing the facility about his or her advance directive decision.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his or her personal property and that other person's in the facility

ADVANCE DIRECTIVE NOTIFICATION

All patients have the right to participate in their own health care decisions and to make advance directives or to execute power of attorney that authorizes others to make Healthcare decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions for unable to communicate decisions. Newhall Oral and Maxillofacial Surgery Group respects and upholds those rights. However, unlike an acute care hospital setting, the oral surgeons at Newhall Oral and Maxillofacial Surgery Group do not routinely perform high-risk procedures. Most procedures performed in this facility are considered to be minimal risk. No surgery is without risk; however, he will discuss the specifics of your procedure with your position who can answer questions as to its risk, your expected recovery, and tear after surgery. It is our policy regardless of the contents of any advance directive more instructions from help care surrogates or attorney in fact oh, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with her wishes, advance directive, or Health Care power of attorney. Your agreement with this facility policy will not revoke or invalidate any current health care directive for healthcare power of attorney.

If you wish to complete an advance directive, copies of the official state forms are available at our facility. If you do not agree with this facility policy, we will assist you in rescheduling your procedure.

PATIENT COMPLAINT OR GRIEVANCE

- If you have a problem or complaint, please speak to the receptionist or your caregiver. We will address your concern promptly.
- If necessary, your problem or complaint will be routed to the administrator and or quality assurance coordinator resolution. You receive a letter or phone call to inform you of the actions taken to address your complaint within 14 days.
- If you're not satisfied with the response of the surgery center, you may contact

All Medicare beneficiaries may file a complaint or grievance with the Medicare beneficiary ombudsman. You may call 1-800 Medicare, and they will direct your inquiry to the Medicare Ombudsman. You may write them at:

PATIENT AGREEMENT ON AUTHORIZATION

FOR THE RELEASE OF MEDICAL AND HEALTH PLAN DOCUMENTS FOR THE CLAIMS PROCESSING AND REIMBURSEMENT AS REQUIRED BY FEDERAL AND STATE LAWS

LEGAL ASSIGNMENT OF BENEFITS AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

In considering the amount of medical expenses to be insured, I, the undersigned, have insurance and or employee health care benefits coverage with the above captions and hereby assigned convey directly to the above named health care providers, as my designated authorized representatives, all medical benefits and or insurance reimbursement if any otherwise payable to me for services rendered from the such providers, regardless of such providers Managed Care Network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named providers to release all medical information necessary to process any claims under HIPAA. I hereby authorize any plan administrator or fiduciary, and sure, in my attorney to release such providers any and all plan documents, insurance policy, and or settlement information upon written request from such providers in order to claim such medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and or employee health benefits claims submissions.

I hereby convey to the above named providers, to the full extent permissible under law and under any applicable employee Group Health Plans, insurance policies, or liability claim, any claim, chose in action, or other right I may have such Group Health Plans, health insurance issuers, or tortfeasors, insurers under any applicable insurance policies, employee benefit plans, or public policies with respect to medical expenses incurred as a result of the medical services I received from the above-named providers, and to the full extent permissible under law to claim or lien such medical benefits, settlement, insurance reimbursement, and any applicable rent remedies including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence, (3) making statements about facts or law; (4) making any requests, or given, or receiving any notice about appeal proceedings, (5) any administrative and judicial actions by such providers to pursue such claim, chose in action, or right against any liable party or employee Group Health Plans, including if necessary, bring suit by such providers against any such liable party or

employee group Health Plan in my name with derivative standing but as such provider(s) expenses, unless revoked, this is assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare an applicable federal laws. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this agreement

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE

I have been informed that Alexei Mizin, DMD, Gennady Landa, DMD, MD, John Scaramella, DDS, Andrei Marechek, MD, DDS are not Medicare providers and that payment is due in full on the day of my visit. I am aware that Medicare may not pay for any or all of the surgical process procedures I may have performed. I have the right to bill Medicare, but I understand that you cannot intercede any issues I may have with my claim. I have been provided a copy of this notice and I understand.

FINANCIAL POLICY

I understand and acknowledge that I am fully and completely responsible for payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the oral surgeon and others in this office. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse, and or my employer. The oral surgeon is not a party to this contract. Therefore, I acknowledge that I am fully responsible for the payment of all sums due to the oral surgeon for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the oral surgery office will bill my insurance company or Managed Care carrier, and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason including but not limited to; insurance company or managed care company declining coverage after their initial approval or if the insurance company or managed care company fails for any reason to reimburse the oral surgeon within 30 days after being billed by the oral surgeon. I acknowledge that it is my responsibility to provide the oral surgeon with my current insurance or Managed Care information and any changes there too.

Cancellation notice: if you need to reschedule or cancel a non-surgical appointment, we require (2) business days' notice. Failure to comply will result in the cancellation fee of $95. For surgical appointments we require (5) business days' notice. Failure to comply will result in a cancellation fee of no less than half of your surgery cost and or forfeiture of your surgery deposit unless prior Agreements are made.

All returned checks will be subject to a $30 returned check fee. Any account balances that remain unpaid for 30 days from the date of service shall accrue interest at a rate of 1.8% per year and may be referred to a collection company or attorney. In the event this occurs, I understand I will be liable for collection costs of $75. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs associated with attorney's fees incurred in the connection therewith.

I consent to the oral surgeons use and disclosure of my health information to my insurance company or managed care company and any agent Vera. I hereby assigned to the oral surgeon all of the insurance and managed care benefits due to me for the services, treatments, procedures, and or diagnostic methods provided to me, and I authorize my insurance company and or managed care company to make payments directly to the oral surgeon for the costs associated therewith.

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I further consent to be contacted by the oral surgeon, any agent of the oral surgery office, or any collection agency or age of thereof or attorney to whom an unpaid account balance has been assigned or referred by mail at any address I provide to the oral surgery office and or by epic simile, email or phone other number whether a cell phone or landline that I have provided to the oral surgery office or any agent of the oral surgery.