Harford County Ambulatory Surgery Center

1952-A Pulaski Highway • Edgewood, MD 21040
410-538-7000 • Fax: 410-679-7825

INITIAL PATIENT REGISTRATON

PATIENT'S NAME: ______________________ DATE: __________
Address: ______________________
City/State : ______________________ Zip: __________
Home Phone #: ______________ Cell #: ______________
SS #: ______________ Date of Birth: ______________
Male or Female: ______________ Marital Status: ______________

EMPLOYER: ______________________ Full or Part Time: __________
Employer Address: ______________________
City/State: ______________________ Zip: __________
Work Phone #: ______________

PRIMARY INS.: ______________________ ID #: __________
Policy Holder's Name: ______________________ SS #: __________
Date of Birth: ______________ Relationship to Patient: ______________
Group #: __________ Benefits Phone #: ______________
Claims Mailing Address: ______________________
City/State: ______________________ Zip: __________
Policy Holder's Employer: ______________________
Address: ______________________
City/State: ______________________ Zip: __________
Phone #: ______________ Full or Part Time: __________

SECONDARY INS.: ______________________ ID #: __________
Policy Holder's Name: ______________________ SS #: __________
Date of Birth: ______________ Relationship to Patient: ______________
Group #: __________ Benefits Phone #: ______________
Claims Mailing Address: ______________________
City/State: ______________________ Zip: __________
Policy Holder's Employer: ______________________
Address: ______________________
City/State: ______________________ Zip: __________
Phone #: ______________ Full or Part Time: __________

PLEASE TURN OVER AND COMPLETE REVERSE SIDE IF WORKER'S COMPENSATION CLAIM OR PERSONAL INJURY CLAIM PERTAINS TO YOU

Work Compensation Claim: ☐ Yes ☐ No

Date of Injury: ______________________________

Full or Part Time: ______________________________

Claim #: ______________________________

EMPLOYER: ______________________________

Employer Address: ______________________________

City/State: ______________________________ Zip: __________

Phone # ______________________________

Work Compensation Ins. Co.: ______________________________

Claims Mailing Address: ______________________________

City/State: ______________________________ Zip: __________

Adjuster Name: ______________________________ Phone #: ______________________________

Attorney Name: ______________________________

Attorney Address: ______________________________

City/State: ______________________________ Zip: __________

Attorney Phone #: ______________________________

Personal Injury Claim AUTO/OTHER DATE OF ACCIDENT ______________________________

PIP Ins. Carrier: ______________________________

Claims Address: ______________________________

City/State: ______________________________ Zip: __________

Adjuster Name: ______________________________ Phone #: ______________________________

HCASC
Harford County Ambulatory Surgical Center

Accredited by

Accreditation Association
For Ambulatory Health Care, Inc.

MEDICARE CERTIFIED

MEDICATION RECONCILIATION

Patient Home Medication List recorded on Admission Date:____________
Allergies: List drug and Reaction

____

____

____

Medications/Vitamins? Herbals: List drug, dose, and how often

Drug	Dose	How often	Last Taken

New/ Additional Medication after discharge

____

____

____

The medication list above is the information you provided our staff, including and any changes we have made.

Patient Signature____________________________
Reviewed by Surgeon/RN_______________________**Date** ____________

Please have this document available to provide a current medication list to your PCP
Revised 2/02/09

HCASC

Harford County Ambulatory Surgical Center

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Accreditation Association
For Ambulatory Health Care, Inc.

MEDICARE CERTIFIED

ADVANCE DIRECTIVES POLICY
HARFORD COUNTY AMBULATORY SURGERY CENTER

The purpose of this form is to provide information to all patients of their rights under Maryland state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

As specialists providing outpatient services in an ambulatory setting, Harford County Ambulatory Surgery Center does not directly address Advance Directives with patients scheduled for procedures at the Center. It is the policy of the Medical Director and staff to honor advance directives presented to them by their patients. However, should an untoward event happen to a patient while he or she is in our Center, it is also our policy to stabilize that patient and transport them to the hospital of their choice with a copy of the advance directive (if made available).

If you would like more information on the Maryland state law regarding Advance Directives, please ask the receptionist or you may go to the website:

http://www.oag.state.md.us/Healthpol/index.htm

I certify that I have read and understand the above information regarding Advance Directives and Harford County Ambulatory Surgery Center's policy regarding them.

(Please check all that pertain)

- ☐ I have formulated my Advance Directives. (Please bring a copy to the center with you.)
- ☐ I have not formulated my Advance Directives.
- ☐ I would like more information on how to formulate Advance Directives.

PATIENT'S SIGNATURE____

DATE________________________

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF YOUR PROCEDURE.

Professional Anesthesia Group, LLC

Authorization and Assignment of Benefits

I, ______________________________, in consideration of the professional services rendered to me by Professional Anesthesia Group, LLC, voluntarily give consent for such treatment, and agree to the following:

Authorization for Release of Information

For the purpose of reimbursement of fees for professional services rendered by Professional Anesthesia Group, LLC, I authorize the release of any necessary information to third party payors, insurance companies, attorneys, or other relevant parties to ensure payment for such services. Information provided by me regarding health care coverage is true and accurate to the best of my knowledge.

Assignment of Benefits

For services rendered, I hereby authorize my insurance company to assign and transfer any benefits due me to be paid directly to Professional Anesthesia Group, LLC. It is agreed that payment to Professional Anesthesia Group, LLC, pursuant to this authorization, by an insurance company, shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this agreement. If after 60 days from the date of services rendered and my insurance has not paid, I will be responsible for all balances due.

Financial Understanding and Guarantee of Payment

I understand that services rendered by Professional Anesthesia Group, LLC will require payment, and I acknowledge complete responsibility for such payment. I hereby obligate myself to pay the account of Professional Anesthesia Group, LLC in accordance with the regular rates and terms of such payment, and guarantee payment within three months from the date of service rendered. I further acknowledge responsibility for payment of all deductibles, co-payments, or other fees not covered by insurers or third party payors incurred by me as a result of services rendered. Should the account be referred to an attorney or licensed collection agency for collections, I shall be responsible for payment of all reasonable attorneys' fees and other collection expenses.

I hereby authorize any benefits due me to be paid directly to Professional Anesthesia Group, LLC in accordance with this assignment. I certify that I am the patient, a duly authorized general agent of the patient, or guardian of the patient, if a minor, and am authorized to execute this document and accept its terms.

______________________________ ______________

Signature Date

______________________________ ______________

Witness Date

Professional Anesthesia Group, LLC.
1311 S. Main Street # 204
Mt. Airy, MD 21771
Phone # (301) 829-7683

Privacy Notice

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 104-191, (The **Health Insurance Portability and Accountability Act of 1996) (HIPAA),** mandates that we issue this new revised **Privacy Notice** to our patients. This notice to our patients meets all current requirements as it relates to **Standards for Privacy of Individually Identifiable Health Information IIHI);** affecting our patients. You are urged to read this notice.

As part of the Privacy Standard, implemented on April 14, 2001, you are required to provide this office with a new, signed and dated, **Consent Agreement**. Every patient must receive our new Privacy Notice and execute a new Consent Agreement before this office may use your information for treatment, payment, or other health care operations (TPO).

Our Privacy Notice informs you of our use and disclosure of your **Protected Health Information (PHI)**, defined as: "any information, whether oral or recorded in any medium, that is either created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past present or future payment for the provision of health care to an individual".

Our office will use or disclose your PHI for purposes of treatment, payment and other healthcare purposes as required to provide you the best quality healthcare services that we offer to the extent permitted by your Consent Agreement or in such specific situations, by your signed and dated Authorization. It is our policy to control access to your PHI; and even in cases where access is permitted, we exercise a "minimum necessary information" restriction to that access. We define the minimum necessary information as the minimum necessary to accomplish the intent of the request.

An Authorization differs from a Consent Agreement in that it is very specific with regard to the information allowed to be disclosed or used, the individual or entity to which the information may be disclosed to, the intent for which it may be disclosed, and the date that it was initiated which may include the duration of the authorization. This is a form, separate from the Consent Agreement, and usually used only for one specific request for information. In the event of a non-healthcare related request for personal health information this office will request you to complete an Authorization Form.

You, as our patient, may revoke any Consent Agreement or Authorization at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI. To revoke either the Consent Agreement or the Authorization you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Authorization or Consent Agreement. Any revocation will not apply to information already used or disclosed.

If you had a "personal representative" initiate as Authorization you may revoke that authorization at any time.

You, the patient have access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information. The physician or principal will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes to the information. If the physician or professional agrees with the request to amend the information, we are bound by law to abide by the changes.

In limited circumstances, The Privacy Standard permits, but does not require, covered entities to continue certain existing

disclosures of health information without individual authorization for specific public responsibilities.

These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or to assist in determining the cause of death; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. There are specific state laws that required the disclosure of health care information related to Hepatitis C, and AIDS. Where the state laws are more stringent than HIPAA Privacy Standard, the state laws will prevail.

All of these disclosures could occur previously under former laws and regulations however; The Privacy Standard establishes new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use our professional judgments to decide whether to disclose any information, reflecting our own policies and ethical principals.

On some occasions we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although we will institute a "chain of trust" contract and monitor our business associates' contracts with us, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way as to violate the Privacy Standard.

Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign this agreement as a condition of receiving care. It is the law that your rights are communicated in this manner.

It is our practice to retain information about non-healthcare related requests for your health care information for a period of six years.

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your IIHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.

Please sign below and date the form indicating that you have received this Privacy Notice.

Thank you.

______________________________ Date: ______________

Signature of Patient or Personal Representative

____

Name printed

Figure 1

Professional Anesthesia Group, LLC.
1311 S. Main Street # 204
Mt. Airy, MD 21771
Phone # (301) 829-7683

Consent Agreement

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not require that health care providers obtain a consent agreement as it relates to the use and disclosure of individually identifiable health information (IIHI), but many practices will continue to use the Consent Agreement for other purposes.

Though not necessary to have your consent to allow us to use or disclose your IIHI to others who will treat you or support in providing you quality health care services, it is important to have your consent to use or disclose your IIHI to health care plans to insure accurate and timely payments for the services rendered. The law requires that we inform you of our policy regarding the protection of your IIHI through our Privacy Notice. We may already have a consent agreement from you. Please refer to our Privacy Notice for a full explanation of how this office will protect your individually identifiable health information (IIHI).

Thank you for your continued confidence in our practice and for supporting our new requirements.

The following is a statement that allows us the necessary latitude to work within the new requirements.

I, ______________________, have been presented with a Privacy Notice explaining my rights regarding my individually identifiable health information (IIHI). I consent to the use and/or disclosure of my IIHI for purposes of treatment, payment or other health care operations (TPO). Other uses of my IIHI will require an authorization from me for the specific intention of disclosure.

Patient: ______________________________ Date: ______________

Privacy Notice

Advanced Medical Management
Multi-Specialty HealthCare
Baltimore Work Rehab, LLC
Harford County Ambulatory Surgery Center
Open MRImages
Painmanagement.bz
Cura Management Technologies

Understanding your health record and information:

By better understanding what is in your record, how your health information is used, and your health information rights, we hope this information will assist you in making more informed decisions when authorizing disclosure to others.

Each time you visit your physician or other health care provider, a record of your visit or encounter is made. Typically, this record contains diagnosis, treatment, and a plan for future care or treatment.

This information, often referred to as your health or medical record, serves as:

- a basis for planning your care and treatment,
- a means of communicating amongst the many health professionals who contribute to your care,
- a legal documentation describing the care you received,
- a means by which you or a third-party payor can verify that services billed were actually provided,
- a source of information for public health officials charged with improving the health of the nation,
- a source of data for medical research,
- a source of data for the facility planning and marketing, and
- as a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Your Health Information Rights:

Although your health record is the physical property of AMM, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a paper copy of the notice of information practices upon request, and a restriction on certain uses and disclosures of your information.

Upon request, you can inspect and obtain a copy of your health record, obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken or for the use of treatment, payment or healthcare operations.

Our Responsibilities:

AMM is required to maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in our facility.

We will not use or disclose your health information without your authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment and Health Operations:

We will use your health information for treatment.

For Example: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team, and record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We may also provide your physician or any subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you are discharged from this center.

We will use your health information for reminders and for follow-up phone calls.

For Example: A member of our nursing or physician staff may call you prior to or after your visit to obtain additional health information, give you instructions about your visit or inquire about your recovery. A member of the billing office may call prior to or after a visit to discuss your financial obligations.

We will use your health information for payment.

For Example: A bill may be sent to you or to a third-party payor. The information obtained identifies you as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For Example: Members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Working with associated businesses:

There are some services provided to our organization through associated businesses. Examples include physician services in radiology, laboratory, pathology and a transcription service we use when compiling your health record. When these services are contracted, we may disclose your information to them so they can perform their function effectively. In order to protect your health information, however, we require these businesses to appropriately safeguard your information.

Directory:

Unless you notify us that you object, we will use your name, location in the facility, and general condition, for directory purposes. This information may be provided to people who ask for you by name.

Advanced Medical Management
3 Nashua Ct., Suite H
Baltimore, Maryland 21221
410-933-5678

Notification:

We may use or disclose information to notify or assist in notifing a family member, personal representative or another person responsible for your care, your location and general condition.

Communication with Family:

Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Communication & Effective Treatment:

This office reserves the right to contact you with appointment reminders or information about treatment alternatives and other health related benefits that may be appropriate to you.

Food and Drug Administration (FDA):

We may disclose to the FDA, health information relative to adverse events with respect to food, supplements, products, product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation:

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health:

As required by law, we may disclose your health information to public or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution:

Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health and the health and safety of other individuals.

Law Enforcement:

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, in the event that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information or to report a Problem:

If you have questions and/or would like additional information, you may contact the Privacy Officer at 410-933-5678 ext. 3310. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer (Attn. Privacy Officer) at the address listed on this page, or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Advanced Medical Management
Multi-Specialty HealthCare
Baltimore Work Rehab, LLC
Harford County Ambulatory Surgery Center
Open MRImages
Painmanagement.bz
Cura Management Technologies

Patient Rights And Responsibilities

Our facilities and medical staff have adopted the following list of patients rights and responsibilities.

The Patient Has The Right To :

- Receive service(s) without regard to age, race, color, sex, sexual orientation, marital status, national origin, cultural, economic, educational or religious background or the source of payment for care.
- Be informed of the services available at the center.
- Be informed of the provisions for off-hour emergency coverage.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and non-physicians who will participate in the care.
- Receive information from his/her physician about his/her illness, course of treatment and prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure that he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
- Participate actively in decisions regarding his/her medical treatment including the right to refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her actions.
- Have pain assessed and managed as part of the treatment process.

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Advanced Medical Management

We have an organizational and ethical responsibility to respect patient's rights, provide considerate and respectful care, affirm patient's rights to make decisions, assist and inform patients regarding their care, illness, marketing practices and admission and discharge practices. We adhere to a code of ethical behavior and policies related to conflict of interest.

The care a patient receives depends partially on the patient him/her self. In addition to patient rights, a patient has certain responsibilities as well. These responsibilities are presented to you, the patient, in the spirit of mutual trust and respect.

Patient Rights (Continued)

- Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely with consideration, respect and dignity. The patient has the right to be advised as to the reason for the presence of any individual involved in their care.
- Be provided information/explanation concerning how their health information is used and disclosed.
- Confidential treatment of all records and communications pertaining to his/her care. Written permission shall be obtained before medical records can be made available to anyone not directly concerned with your care.
- Reasonable responses to any reasonable requests he/she may make for service.
- Leave the Center even against the advice of physicians.
- Be informed regarding patient billing practices, charges for services, eligibility for third party reimbursements and when applicable the availability of reduced cost care.
- Receive a copy of his/her account statement upon request.
- Voice grievances and recommend changes in policies and services to the Center's staff, Privacy/Ethics Officer or the Maryland State Department of Health without fear of reprisal.

Patient Responsibilities

- *The patient* must provide accurate and complete information concerning his/her present condition or complaints, past medical history and other matters about his/her health.
- *The patient* is responsible for making it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.
- *The patient* is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.

Patient Responsibilities (Continued)

- *The patient* is responsible for familiarizing him/her self with his/her insurance policy coverage and for assuring that the financial obligations toward his/her care and treatment are fulfilled as promptly as possible.
- *The patient* is responsible for following facility policies and procedures.
- *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/her personal property, other person's personal property in the facility and property of the facility.
- *The patient* is responsible for providing complete and accurate information including his/her full name, address, home telephone number, date of birth, Social Security number, insurance carrier, and employer when it is necessary.
- *The patient* is responsible for keeping appointments, being on time for appointments, and calling as soon as possible if he/she cannot keep his/her appointments.
- *The patient* is responsible for abiding by all the rules and regulations of this healthcare facility.

Grievance Policy

To make suggestions to the organization and/or to express grievances about any aspect of your experience with the Center, please contact the Privacy Officer at

410-933-5678 ext. 3310

or write to:

Attn: Privacy Officer

3 Nashua Ct., Suite H
Baltimore, Maryland 21221

Accredited by
Accreditation Association
For Ambulatory Health Care, Inc.

MEDICARE CERTIFIED

To: ___________________________

____

____

Dear Patient:

This is to inform you that your SURGICAL PROCEDURE has been scheduled for_____________________ and will be performed at:

HARFORD COUNTY AMBULATORY SURGERY CENTER
1952 Pulaski Highway
Edgewood, Maryland 21040
Phone: 410-538-7000, ext 100

Your arrival time will be 1 hour before your scheduled procedure. YOU WILL RECEIVE A PREOP CALL FROM A NURSE PRIOR TO YOU PROCEDURE TO CONFIRM THE TIME AND TO DISCUSS PREOPERATIVE INSTRUCTIONS. IF YOU DO NOT RECEIVE A CALL BY 3PM THE DAY BEFORE YOUR PROCEDURE, PLEASE CALL US AT 410-538-7000 EXT 103. IF YOU GET A RECORDING, PLEASE LEAVE YOUR NAME AND PHONE # AND WE WILL CALL YOU BACK. PLEASE BE AWARE THAT DUE TO SAME DAY CANCELLATIONS, YOU COULD BE CALLED AND ASKED TO COME IN EARLIER THE DAY OF THE PROCEDURE—PLEASE KEEP THIS IN MIND AND KEEP THE WHOLE DAY OPEN FOR IT.

IT IS IMPORTANT THAT YOU DO THE FOLLOWING:

- **Please have all blood work and/or preadmission testing and surgery authorization done at least 2 to 3 weeks before your surgery. Not doing so could result in your surgery being cancelled.**
- Do not eat or drink anything after midnight the night before your procedure. And nothing on the morning of the procedure--this includes water, gum, mints, coffee, juice etc.
- Do not drink any alcoholic beverages for 24 hours before or after your procedure.
- You must bring a responsible adult with you to the surgery center and they must be able to drive you home after the procedure. That person **must**

stay at the facility while you are here. **You cannot be dropped off and you cannot be discharged alone to a taxi.** You must also have a responsible person with you for the rest of the day and are encouraged to have someone with you during the night after your procedure. You should wear glasses instead of contact lens and shower or bathe the morning of your surgery.

- If you normally take medication or use inhalers (with the exception of diabetic medications), they should be taken as usual but only with a sip of water.
- Please list all your current medications on the attached Medication Reconciliation sheet.
- Do not take any aspirin, Advil, blood thinners, vitamin E, herbal medicine or over the counter medicines at least 2 weeks prior to surgery.
- Please fill out the attached forms ahead of time so your registration will not delay your procedure.
- Please understand if you do not follow the instructions or if your physical condition changes, your procedure may be cancelled.
- IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS, PLEASE NOTIFY YOUR PHYSICIAN IMMEDIATELY BECAUSE YOU WILL NOT BE ABLE TO BE DONE AT THE SURGERY CENTER: **LATEX ALLERGY, FAMILY HISTORY OF MALIGNANT HYPERTHERMIA, WEIGHT GREATER THAN 350 LBS. OR A CARDIAC STENT PLACED LESS THAN 6 MONTHS AGO.**
- If you are a private insurance patient, it is your responsibility to familiarize yourself with your insurance policy coverage and for assuring that any financial obligations regarding your care and treatment at the surgery center are fulfilled as promptly as possible. As a courtesy to you, we will contact your insurance company to verify facility coverage and notify you of any facility co-pay due the day of your surgery. We do not take responsibility for verifying your physician's charges.

IF YOU HAVE ANY QUESTIONS REGARDING THIS PROCEDURE, PLEASE CONTACT DR. XXXXXXXX OFFICE AT XXX-XXX-XXXX.

SINCERELY,

Kimberly Merrill, BSN, RN
Nurse Administrator

DIRECTIONS TO:
HARFORD COUNTY AMBULATORY SURGERY CENTER

FROM BALTIMORE:

Take 695 to I95 north to exit 74 (Joppatowne/Fallston). Make a right off the exit onto Rt. 152 (Mountain Rd). Go to the second stoplight and make a left which will be Rt. 40 (Pulaski Hwy,). Go through the next three stoplights, (Paul Martin Drive will be the third light), after passing through the third light there will be a break in the road in which you will want to make a u-turn. We are located on the right next to Wendy's.

OR

From East Baltimore you can come out Rt. 40 (Pulaski Hwy). Go past Baltimore County and through Joppatowne. A little further out will be Rt. 152 (Mountain Rd./Magnolia Rd.). After passing through the light at Mountain Rd. go through the next three lights (Paul Martin Drive will be the third light), after the passing through the third light there will be a break in the road in which you will want to make a u-turn. We are located on the right next to Wendy's.

FROM NORTH:

Take I95 South to exit 74 (Joppatowne/Fallston). Make a left off of the exit. Go to the third stop light and make a left, which will be Rt. 40 (Pulaski Hwy.). Go through the next three stoplights, (Paul Martin Drive will be the third light), after passing through the third light there will be a break in the road in which you will want to make a u-turn. We are located on the right next to Wendy's.

Pull onto the parking lot and enter the building through the door with the blue awning.

If you have any questions, please feel free to call the Surgery Center at 410-538-7000. We will be glad to help you.