3444 KEARNY VILLA RD, SUITE 100 · SAN DIEGO, CA 92123 · 858.268.3566

WWW.COASTSURGERY.COM

What is an ASC?

ASCs are facilities for surgical patients who do not need to be admitted to the hospital. ASC patients typically arrive for admission, have surgery performed in a full-service operating room with specialized staff, recover safely and quickly from anesthesia and return home within hours of their surgery.
Some procedures require patients to stay for several hours to allow nurses to monitor their recovery.

What type of surgeries are performed at ASCs?

Depending on the ASC, the center may specialize in one or multi-service lines. Our center specializes in orthopedic procedures and podiatry, spine, pain management, general surgery, ear, nose and throat, and gynecological procedures.

Our goals are to provide:

1. A great patient experience
2. Great results
3. Convenient, flexible scheduling, and on start time of surgery.
4. Clean pleasant atmosphere
5. Friendly and highly trained staff
6. Access to the latest minimally invasive technology
7. Safer– ASCs have lower infection rates than most hospitals

You have selected COAST Surgery Center, a federally recognized Medicare Certified Ambulatory Surgery Center, for your health care services. Your physician may or may not have an ownership interest in the Surgery Center as not all physicians who practice here have an ownership interest. As a patient, you have the right to receive a list of all physician owners in this facility, upon request.

Why Choose an ASC?

ASCs are on the cutting edge of technology often utilizing the most current surgical innovations with the least invasive techniques allowing patients to return to their normal lifestyle sooner. ASCs are efficient, understanding that everyone's time is important. Their convenient surgical flow allows you less wait time and less bureaucracy and offers patient-friendly family-centered environments.

Many ASCs have undergone a rigorous accreditation process performed by an independent accrediting agency. You may find these accreditations posted in your local ASC. These accreditations may include Joint Commission on Accreditation of healthcare Organization (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC) or the American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF).

COAST Surgery Center is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC).

Patient's Statement of Rights and Responsibilities

This Surgery Center has adopted the following list of Rights and Responsibilities for the Patients:

A PATIENT HAS THE *RIGHT* TO…

- Receive information about rights, patient conduct and responsibilities prior to surgery or procedure.
- Receive care in a safe setting that is free from all forms of abuse, neglect or harassment. Be treated with respect, consideration and dignity.
- Be provided appropriate personal privacy.
- Know what patient support services are available, including whether an interpreter is available if he/she does not speak English.
- Be provided, to the degree known, complete information concerning diagnosis, evaluation, treatment and who is providing services and who is responsible for the care. When the patient's medical condition makes it inadvisable or impossible, the information is provided to a person designated by the patient or to a legally authorized person.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed and given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- Have disclosures and records treated confidentially and be given the opportunity to approve or refuse record release except when release is required by law.
- Exercise his or her rights without being subject to discrimination or reprisal with impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical disability, or source of payment.
- Be informed on how to exercise the right to voice complaints and grievances regarding treatment or care provided or lack of without reprisal.
- Have a person appointed under State law to act on the patient's behalf if the patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction. If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.
- Refuse treatment to extent permitted by law and be informed of medical consequences of this action.
- Know if medical treatment is for purposes of experimental research and to give his/her consent or refusal to participate in such experimental research.
- Have the right to change his primary or specialty physicians or dentists if other qualified physicians or dentists are available.
- A prompt and reasonable response to questions and requests.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care and know, upon request and prior to treatment, whether the facility accepts the Medicare assignment rate.
- Receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- Know the facility policy on advanced directives.
- Formulate advanced directives and to appoint a surrogate to make health care decisions on his/her behalf to the extent permitted by law and provide a copy to the facility for placement in his/her medical record.
- Be informed in writing the names of physicians who have financial interest and ownership in the facility.
- Have properly credentialed and qualified healthcare professionals providing patient care.
- Be fully informed of the scope of services available at the facility, provisions for after-hours emergency care and related fees for services rendered him or her.

A PATIENT IS *RESPONSIBLE* FOR…

- Providing a responsible adult to transport him/her home from the facility and remain with him/her 24 hours, unless specifically exempted from this responsibility by his/her provider.
- Providing to the best of his/her knowledge, accurate and complete information about his/her health, present complaints, past illnesses, hospitalizations, any medications, including over-the-counter products and dietary supplements, any allergies or sensitivities, and other matters relating to his/her health.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Following the treatment plan recommended by his/her healthcare provider.
- Be respectful of all the health providers and staff, as well as other patients.
- Providing a copy of information that you desire us to know about a durable power of attorney, health care surrogate, or other advanced directive.
- His/her actions if he/she refuses treatment or does not follow the health care provider's instructions.
- Report unexpected changes in his/her condition to the health care provider.
- Reporting to his/her healthcare provider whether he/she comprehends a contemplated course of action and what is expected of him/her.
- Keeping appointments.

PATIENT CONCERNS AND/OR GRIEVANCES:
Please contact us if you have questions or concerns about your rights or responsibilities. You can ask any of our staff to help you contact the following:

Alice Ramirez, Administrator
COAST Surgery Center
3444 Kearny Villa Rd, Suite 100
San Diego, CA 92123
(858) 268-3566 x 333

CA Dept. Of Public Health, Licensing & Certification
Attention: District Manager
7575 Metropolitan Dr, #104
San Diego, CA92018
(619) 767-2060
(800) 554-0354 or (866) 784-0703

AAAHC
5250 Old Orchard Rd, Suite 200
Skokie, IL 60077
(847) 853-6060

If you are covered by Medicare, you may choose to contact the Medicare Ombudsman at 1-800-MEDICARE (1-800-633-4227) or online at www.Medicare.gov/ombudsman/resources.asp.

The role of the Medicare Beneficiary Ombudsman is to ensure that Medicare beneficiaries receive the information and help your need to understand your Medicare options and to apply your Medicare rights and protections.

COAST Surgery Center is Medicare certified and is accredited by the Accreditation Association for Ambulatory Health Care, Inc.

ADVANCE DIRECTIVES:
An "Advance Directive" is a general term that refers to your oral and written instructions about your future medical care, in the event that you become unable to speak for yourself. Each state regulates the use of advance directives differently. There are two types of advance directives: a living will and a medical power of attorney.
If you would like a copy of the official State advance directive forms, visit: http://www.calhospital.org/sites/main/files/file-attachements/forms_3.pdf.

OUR SURGERY CENTER'S ADVANCE DIRECTIVE POLICY:

The majority of procedures performed at the Surgery Center are considered to be of minimal risk. Of course, no surgery is without risk. You and your surgeon will have discussed the specifics of your procedure and the risks associated with your procedure, the expected recovery and the care after your surgery.

It is the policy of the Surgery Center, regardless of the contents of any advance directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at the Surgery Center, the personnel at the Surgery Center will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive, or health care power of attorney.

I received information on patient rights, patient responsibilities, physician disclosure, advance directive policy, and grievance policy at least one day in advance of my surgery.

Print Name: _____

Signature: _____

Date: _____

Date of Service: _____

Ride verification memo from patient:

Ride Name: include (relationship to patient)

Ride Name: _____ Ride Number: _____

Relationship to Patient: _____

Coast Surgery Center may communicate information related to my surgery and discharge orders to the person(s) noted above for today's date of service only.

The person(s) listed above will care for me after surgery for 24 hours.

If alternate person/group is caring for you, please list below name and contact number.

Name: _____ Contact Number: _____

_____ _____
Patient Signature Date

Patient Advisory and Acknowledgment

Receiving Surgical Treatment During the COVID-19 Pandemic

Dear Patient:

While our surgery center complies with state health department and the Centers for Disease Control and Prevention (CDC) infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees. Our staff, your surgeon, and your anesthesia personnel are symptom-free and, to the best of their knowledge, have not been exposed to the virus.

Since this facility is a provider of healthcare services, persons (including other patients or staff) could be exposed or infected, with or without their knowledge. In order to reduce the risk of spreading COVID-19, we have employed reasonable precautions including preoperative screening of patients and daily screening of healthcare workers and all essential individuals entering the facility.

This information is provided to assist you in making an informed decision regarding the risks and benefits of your scheduled procedure during this time.

By signing below you are acknowledging your participation in the COVID-19 screening process, the truthfulness of your responses, and that you have discussed COVID-19 related risks with your surgeon.

Thank you for choosing COAST Surgery Center.

Patient Printed Name: _____

Patient Signature: _____

Date: _____

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PATIENT FINANCIAL AGREEMENT

To Patient/Responsible Party

I understand that I am responsible to pay any co-pays, deductible and/or co insurance amounts on the ***Day Of Service*** not covered by my insurance company.

In the event there is a remaining balance, I agree to pay any balance due within 90 days of receiving my first billing statement.

I have the option to pay my account in full via Cash, Check, Visa, M/C, Amex, Discover or online at www.coastsurgery.com and select the "pay my bill" link within 90 days or risk my account being sent to an outside collection agency.

I understand that if my insurance company sends me a check for my services rendered at Coast Surgery Center I will forward the payment to the surgery center immediately.

If this procedure is being done on a workers' compensation basis, this form does not apply.

Patient/Responsible Party Signature Date

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RELEASE OF RECORDS

In an effort to provide continuity of care and best patient outcomes it is important and may be necessary to share relevant information regarding your care in the event of a hospital transfer or admission to another facility.

In the event of a **hospital transfer** or issue related to **today's date of service:**

- I hereby authorize Coast Surgery Center to release the records for this date of service to the receiving hospital or new admitting facility.

  * Please note, Coast Surgery Center will not release Protected Health Information to anyone not directly involved with your care.

- I hereby authorize the receiving hospital, clinic or physicians office to release the ***hospital discharge summary***, ***post office visit notes, labs and or studies*** for today's date of service to Coast Surgery Center.

_____ _____

Patient Signature Relationship

_____ _____

Date Signed Witness

_____

Interpreter Signature

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PATIENT EMERGENCY CONTACT & FOLLOW UP COMMUNICATION

In the event of an emergency who should we contact?
Name of Emergency Contact: _____

Phone Number of Emergency Contact: _____

In our efforts at streamlining doctor/patient communications and to help maintain your privacy, please take a moment to answer the following questions:

What is the best telephone number to reach you with information related to your visit?

- Home phone: _____
- Work phone: _____
- Cell phone: _____

Circle Selection

- Your physician at Coast and or the Coast staff **(may/may not)** leave a message for me on the voicemail system.
- Your physician at Coast and or the Coast staff **(may/may not)** leave a message for me with members of my family (spouse, children etc.) or other people involved in my care.

Please list any specific instructions related to our communication process:

_____

_____

_____

_____ _____

Patient Signature Date

COAST Surgery Center is committed to providing the highest level of care. To achieve this objective we ask our patients or their caretaker to complete a brief patient satisfaction survey after their surgery.

To better serve you we have automated his process. Within 48 hours of your discharge from our facility, you will receive an email providing you with a link to complete our survey. The survey is performed online via secure internet connection to the independent company we have hired to gather survey results. Simply follow the instructions and give us your feedback. Patients who complete the online survey will be entered into a monthly drawing for a $100 gift certificate to Amazon.com

Please write legibly and provide the email address to forward the survey in the boxes below:

If you do not have access to email or a computer, please let us know and we will provide you with a paper version of this survey to complete and mail to us.

Privacy Statement: We are committed to protecting the confidentiality of our patient's information and identities. Under no circumstances will your information be disclosed or used for marketing purposes.

Patient Information

Mr. Mrs. Ms. Miss _____
Last Name First Middle

Address _____

Home Phone _____ Mobile Phone _____

Date of Birth _____ SS #

Parent/Legal Guardian (if patient is a minor) _____

Name & Phone # of Friend/Relative not living with you _____

Employer _____ Employer Phone _____

Primary Insurance Company Name

Name of Sponsor _____ ID # _____

Date of Birth of Sponsor _____ SS# of Sponsor _____

Secondary Insurance Co. Name (If applicable) _____

Name of Sponsor _____ ID # _____

Date of Birth of Sponsor _____ SS# of Sponsor _____

Was your injury the result of an accident (check one)? Yes ( ) No ( )

Work Related ( ) Auto Accident ( ) Personal Injury ( ) N/A ( )

Date of injury _____ Injury Details _____

Workers' Compensation Carrier and Address _____

WC Claim # _____ Adjustor Name _____

Name and Phone# of Attorney (if applicable) _____

I certify that the information above is accurate, truthful and complete to the best of my knowledge.

Signature _____ Date _____

3444 Kearny Villa Road, Suite 100 * San Diego, CA 92123 * 858.268.3566 * Fax 858.268.4682 * www.coastsurgery.com

PATIENT FINANCIAL AGREEMENTS

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by Coast Surgery Center and are accessible to Coast Surgery Center personnel and medical staff. Coast Surgery Center personnel and physicians in attendance may use and disclose medical information for surgery center operations and functions and to any other physician or health care personnel involved in my continuum of care for this admission. Safeguards are in place to discourage improper access. Coast Surgery Center and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or self-insured employer group liable for any part of Coast Surgery Center's charges and to any health care provider who is or may become involved with my care.

RELEASE OF RESPONSIBILITY

Coast Surgery Center is hereby released from any responsibility for any items of personal property I do not provide to it for safekeeping.

ASSIGNMENT OF GROUP HEALTH/MEDICARE INSURANCE BENEFITS

I agree that insurance benefits for Coast Surgery Center charges payable to the insured are to be made payable to Coast Surgery Center. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. I understand that I am responsible for any balance after insurance payment, including all costs incurred in collecting the balance if the account becomes delinquent, such as court costs, attorney's fees and/or collection agency commissions or charges.

WORKERS' COMPENSATION INSURANCE BENEFITS

I understand that if I am being treated for an approved work-related injury that Coast Surgery Center will obtain reimbursement from my workers' compensation carrier directly. I understand that if my claim is found to be non-compensatory according to the Workers' Compensation Appeals Board retroactively, that I will then become fully responsible for all charges.

FINANCIAL RESPONSIBILITY

As consideration for the services provided me, payment is guaranteed for any amount due for such services provided by Coast Surgery Center unless otherwise agreed to in writing by Coast Surgery Center. I understand that I may receive additional bills relating to my surgical services, including, but not limited to physician/surgeon professional, assistant surgeon, anesthesia, lab and third party vendor services.

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of this Patient Agreement, I further certify that I am the patient, or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by this facility is in our PRIVACY NOTICE, which you should read before signing this agreement. A copy is included in your admissions packet and is posted throughout Coast Surgery Center.
I have received a copy of Coast Surgery Center's Notice of Privacy Practices.

_____ _____

Patient Signature Relationship

_____ _____

Date Signed Witness

_____

Interpreter Signature

Basis for refusal, if refused: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

I have received the notice of Privacy Practices. This Notice provides information about how my protected health information may be used or disclosed.

Date _____ Time _____ Signature (Patient/Representative) _____

If signed by other than the patient, print name and relationship.

Name _____ Relationship _____

Witness(es) (2) only required for telephone consent, physical inability to sign, or signature by mark:

Date _____ Time _____ Witness _____ Witness _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT (Complete Only If No Signature Is Obtained)

A good faith effort has been made to obtain the acknowledgement above. At this time, the following circumstances exist:

The patient refuses to sign

The patient is not able to sign and there is no legal representative available.

Date _____ Time _____ Signature of Employee _____

Notice of Privacy Practies

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Who Will Follow This Notice

This notice summarizes the privacy practices of health care providers within Coast Surgery Center.

Federal and State Law

Federal and state laws require Sutter Health to protect your health information and federal law requires Sutter Health to describe to you how we handle that information. When federal and state privacy laws differ, and the state law is more protective of your information or provides you with greater access to your information, then we comply with the more stringent state law.

Your Rights

When it comes to your health information, you have rights. You may contact Coast Surgery Center at 1-858-268-3566 to exercise the following rights:

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
- You have to put your request in writing and we will provide you with access to your medical record.

Additional Applicable State Law Requirements:

California law generally requires access to be provided within five (5) business days.

We will provide a copy or, if you prefer, a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Additional Applicable State Law Requirements:

California law requires provision of your record within fifteen (15) days of your request.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. You have to put your request in writing.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We require you to ask us in writing, but we will honor any reasonable request.

Ask us to limit what we use or share

- You can ask us, in writing, not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights:
  Coast Surgery Center
  Attn: Alice Ramirez
  3444 Kearny Villa Road
  Suite 100
  San Diego, CA 92123
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.
- *We will not retaliate against you for filing a complaint.*

Your Choices

For certain health information, you can tell us your choices about what we share. Let us know if you have a clear preference for how we share your information in the situations described below. We will follow your instructions where we can.

In these cases, you have both the right and choice to tell us to:

- Share (or not share) information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may still be able to share minimal information if we believe it is in your best interest or when needed to lessen a serious and imminent threat to health or safety.

Fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again. If you change your mind, you can always ask to start receiving fundraising information again.

Our Uses and Disclosures

We use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you. We may use your health information to provide you with medical care in our facilities or in your home. We may also share your health information with others who provide care to you such as hospitals, nursing homes, doctors, nurses, or others involved in your care. We may share your information with third party transportation providers, such as ridesharing or taxi services, to facilitate your transportation needs.

> *Example*: *Your doctor speaks with a behavioral health professional within our clinic about getting you help for an anxiety disorder.*

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

> *Example*: *We use health information about you to manage your treatment and services.*

Coast Surgery Center may use and share your health information to support necessary business, legal, auditing, financial and clinical functions. Examples of these functions may include: auditing our clinical procedures, analyzing our cost of care, arranging for patient satisfaction surveys, fundraising and determining the need for new health care services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your health information for health research.

Additional Applicable State Law Requirements:

Oregon law protects the genetic privacy of individuals and gives you the right to decline to have your health information or biological samples used for research. We will provide you with a separate notice where you can make your choice known to us.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Health Information Exchange

Coast Surgery Center participates in electronic exchange networks and some of the uses and disclosures of information described above may be done through electronic means, such as a Health Information Exchange ("HIE"). Other entities may access your health information for treatment or other permitted uses.

Example: Health information may be securely exchanged between your treating health care providers at different organizations to coordinate your care.

For additional information about HIEs or to learn how you can opt-out of having your information shared through HIE, visit our webpage at: http://www.sutterhealth.org/yourhealth/health-information-exchange.html

Business Associates

There are some services provided in our organization through contracts with business associates. Examples include transcribing your medical record, surveying for patient satisfaction, and a copy service we use when making copies of your health record. When services are provided by contracted business associates, we may disclose the appropriate portions of your health information to them so they can perform the job we have asked them to do. However, our business associates are also required by law to safeguard your information.

Other Uses of Health Information

Uses and disclosures of health information that are not discussed by this notice or required by law will only be made with your written permission. Your written authorization will typically be required for most uses and disclosures of psychotherapy notes, if you receive treatment in an addiction treatment program, most uses and disclosures for marketing and most arrangements involving the sale of health information. We comply with state and federal laws that require extra protection for your health information. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time.

Additional Applicable State Law Requirements:

California: Your written authorization will typically be required for most uses and disclosures of HIV test results, outpatient psychotherapy information, involuntary commitment records, and alcohol and drug abuse treatment information.

Utah: Your written authorization will typically be required for most uses and disclosures of confidential communications provided to a psychologist, licensed substance abuse counselor, or mental health therapist.

Oregon: Your written authorization will typically be required for most uses and disclosures of genetic information, and alcohol and treatment information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/ consumers/noticepp.html

Changes to the Terms of this Notice

We may change our Notice of Privacy Practices from time to time. The changes will apply to all health information we have about you. The new notice will be available upon request at Coast Surgery Center.

Contact: If you have any questions, you may contact:

Coast Surgery Center
Attn: Alice Ramirez
3444 Kearny Villa Rd.
Suite 100
San Diego, CA 92123
(858) 268-3566

Effective Date: October 01, 2020