ASC Disclosure
Fox Valley Orthopedic
Ambulatory Surgery Center
2525 Kaneville Road
Geneva, IL 60134
Phone: (630) 513-2635

Account #: _____

Always First.

PHYSICIAN OWNED FACILITY

The physicians listed below are on staff at Fox Valley Orthopedic Ambulatory Surgery Center and are owners of the ASC. You may choose to have your surgery in a facility not owned by physicians. By signing below you acknowledge that you have been given this option and choose to have your surgery at the Fox Valley Orthopedic Ambulatory Surgery Center.

_____ Initial

Dr. E. Bartel	Dr. J. Jacoby	Dr. C. Torosian	Dr. V. Mehta	Dr. L. Matteini
Dr. D. Morawski	Dr. K. Chakour	Dr. T. Petsche	Dr. J. Sostak	
Dr. J. Alpert	Dr. S. Minhas	Dr. M. Kogan	Dr. J. Seeds	

PATIENT BILL OF RIGHTS

_____ Initial

I have received and understand the Fox Valley Orthopedic Patient Bill of Rights.

ADVANCED DIRECTIVES

_____ Initial

Fox Valley Orthopedic Ambulatory Surgery Center may decline to honor Advanced Directives. Unexpected complications due to anesthesia or surgery are not natural causes, this means if a complication occurs during your treatment at this facility, we will initiate rescue measures and transfer you to Delnor Community Hospital. The hospital will then determine further treatment or withdrawal of treatment in accordance with your wishes, Advance Directive, or Health Care Power of Attorney. The hospital is not affiliated or in partnership with Fox Valley Orthopedic ASC. If you do not have an Advance Directive and would like information and a form to complete a directive, you may get this information from any staff member.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS/FACILITY

_____ Initial

I understand my insurance company may send payments to me for rendered services. I hereby assign to the above named physicians all surgical, medical insurance, and/or other benefits including third party liability, if any, otherwise payable to me for their services at the surgery center. The surgery center is also authorized to release information for the purposes of insurance processing. I understand that any insurance benefits quoted to the surgery center do not guarantee payment and as this is a contract between my insurance company and me, I am ultimately responsible for any and all charges the insurance fails to pay. I agree to endorse over to the surgery center any check which may be made payable to me for services provided by the surgery center and understand that by using insurance proceeds for my personal use, I have committed insurance fraud.

GRIEVANCE PROCEDURE

_____ Initial

Fox Valley Orthopedic ASC values you as a patient and is dedicated to ensuring your relationship with us is a positive one. If we can enhance that relationship in any way, please let us know. Every patient has the right to express complaints to any staff member about the care and services provided. If the patient is not satisfied with the resolution, the complaint is taken to the Director of Surgery. A formal grievance form can be obtained from the Receptionist. The patient, the patient's representative, or the patient's surrogate may also file a written complaint/grievance with the Director of Surgery to the above address. The Director of Surgery will provide you a written response within fourteen (14) days from the date of receipt of the complaint or grievance. The patient has the right to complain to the following agencies if our response is not satisfactory:

Illinois Department of Public Health (217) 782-4977 http://www.idph.state.il.us/home.htm	Medicare Beneficiary Ombudsman (800) 633-4273 www.medicare.gov/claims-and appeals/medicare-rights/get-help/ombudsman.html

By signing below, you, your representative, or your surrogate acknowledge that you have received, read, and understand this information in advance of the date of the procedure and have decided to have your procedure performed at this surgery center.

_____
Print Name

_____ _____
Signature of Patient or Responsible Party Date

For questions regarding the above information, please call **630-513-2635**