SURGICAL ARTS CENTER

9499 W. CHARLESTON, SUITE 250 • LAS VEGAS, NV 89117
702 933-3600 fax 702 933-3601

Acct #: ____________________

PATIENT INFORMATION

Last Name: ____________________ (Jr., Sr., etc.) Sex: M or F Race: ____________

First Name: ____________________ Middle Initial: ______ Preferred Language: ____________

Street Address: ____________________ Apt. / Space: ____________

City: ____________________ State: ____________ Zip Code: ____________

Home Telephone: ____________ Cell Phone: ____________ Work Phone: ____________

Date of Birth: ____________ Age: ____________ Social Security #: ____________

Ethnicity: Hispanic Non-Hispanic Latino Non-Latino Refuse to Report **Marital Status:** M S D W

Email: ____________________ Patient's Employer: ____________________

Referring Physician: ____________________

Patient's Employment Status: Full-time Part-Time Retired Self Employed Active Duty Not Employed

(If Patient is a minor)

Responsible Party: ____________________

Address: ____________________ City: ____________ State: ________ Zip Code: ____________

Phone: ____________________ Employer: ____________________

Email: ____________________

PRIMARY INSURANCE INFORMATION			SECONDARY INSURANCE INFORMATION		
Name of Insurance Co.	Phone Number	Effective Date	Name of Insurance Co.	Phone Number	Effective Date
Insurance Company Claims Address			Insurance Company Claims Address		
Name of Insured	Relationship to Patient		Name of Insured	Relationship to Patient	
Insured's SS#			Insured's SS#		
Policy ID	Group ID		Policy ID	Group ID	
Insured's Employer			Insured's Employer		
Employer Address	Date of Birth of Insured		Employer Address	Date of Birth of Insured	

Part of Body being treated? RT or LT or Both (please circle) ____________________

How were you injured? ____________________ Date of Injury ____________

On The Job Injury? ☐ Yes ☐ No **Auto Accident?** ☐ Yes ☐ No

Workers' Comp Adjuster's Name: ____________________ Phone: ____________ Claim #: ____________

Do you have an Attorney pertaining to this injury? ☐ Yes ☐ No If yes, Attorney's Name: ____________ Phone: ____________

NEXT OF KIN INFORMATION OR EMERGENCY CONTACT

Name: ____________________ Relationship: ____________________

Address: ____________________ Phone ____________________ Home/Cell

I hereby authorize payment of medical benefits to SURGICAL ARTS CENTER for services furnished me. I also authorize the Surgical Arts Center to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. I hereby consent to and authorize medical treatments, tests, and procedures that my physician deems advisable and necessary based on his judgement.

Patient's Signature or Responsible Party Signature ____________________ Date ____________

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NOTICE TO PATIENT, INSUREDS AND GUARANTORS
HEALTH PLAN DENIALS

Your Health Plan will only pay the Surgical Center for the services you receive if they are covered under the terms and conditions of the Health Plan. If you are a member of a preferred provider organization, health maintenance organization or other managed care plan, your Health Plan may reduce or deny your benefits if:

- The services are not Medically Necessary;
- The services are not provided in a Health Plan surgical center;
- The services are not approved, ordered or performed by a Health Plan physician; or
- The services is not a covered service.

Health Plans review surgery centers services to determine if the services are Medically Necessary. Generally, Medically Necessary means services, which are:

- Appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition;
- Within recognized standards of medical practice;
- Not primarily for the convenience of the Health Plan member, the member's family or the Health Plan physician; and
- The least costly of alternative supplies or levels of services which can be safely and effectively provided to the patient.

The Surgical Center cannot accept financial risk for services which you request, or your physician orders, which are subsequently determined to not be Medically Necessary. Your financial agreement with the Surgical Center is to pay for all services you receive whether or not the Health Plan determines the services to be a covered service or Medically Necessary.

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's agent, insured or guarantor, and accepts its terms.

Patient______________________________ Witness______________________________

Date________________________

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FINANCIAL POLICY, ASSIGNMENT OF BENEFITS, & DISCLOSURE OF OWNERSHIP

All fees for medical care are based on the usual, reasonable, and customary fee charged in this area by physicians of equal training and experience.

PAYMENT FOR MEDICAL SERVICES RENDERED ARE DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. **This means that you will be expected to pay your insurance co-payment/co-insurance at each visit.** There will be a $25.00 service charge for any checks returned to our office. ALL ACCOUNTS 90 DAYS PAST DUE MAY BE ASSIGNED TO A COLLECTION AGENCY UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. In the event of collection proceedings due to lack of payment on my part or my insurance company, I gree to pay any and all collection fees that may be added to my account in order to recover monies due the doctor or group.

Late Fee: *You acknowledge and agree that we will necessarily incur direct and indirect costs and expenses as a result of any failure by you to make prompt and timely payment for services provided. Accordingly and to the extent the law allows, in the event your account becomes more than 90 days delinquent, you agree we may add a late fee of 12% APR or $5.00 per month, whichever is greater, to the unpaid amount of your account to offset the additional direct and indirect costs we will have to incur to recover your outstanding medical bill.*

Our office verifies eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your status. We will do all we can to assist you with your insurance claims; however, insurance is a contract between you and your insurance carrier. Final responsibility for payment of your account rests with you. The exception is for those patients with injuries that are work-related and are covered by Worker's Compensation. Those patients are not responsible for their bills unless their claim is denied.

Prior authorizations obtained for procedures by this office on your behalf do not guarantee payments but rather are based on medical necessity. Claims are subject to policy provisions, and your insurance carrier determines final payment. A deposit is required if you are being scheduled for surgery. If an assistant is required at the time of surgery to improve the quality of your surgical outcome, the assistant's fee is in addition to the surgeon's fee.

Having read the above, I hereby authorize payment by my insurance carrier or other designated payor of medical benefits to SURGICAL ARTS CENTER, for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of the assignment is considered as valid as the original.

I also authorize SURGICAL ARTS CENTER to release to my insurance carrier, other designated payors of medical benefits, or their agents, any medical information about me needed to determine these benefits or the benefits payable for service.

I hereby consent to and authorize medical treatment, tests, and procedures performed in the surgery center that my physician deems advisable and necessary based on his judgement. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

By Signing this form, I consent to receive billing reminders, payment options and other information about my billing statements from Surgical Arts Center or its affiliates through the phone number that I have provided. SURGICAL ARTS CENTER is owned by Dr. Steven Thomas who also performs procedures at this facility.

_______________________________________ _______________

Patient's or Responsible Party's Signature Date

____

Patient's or Responsible Party's Printed Name

SURGICAL ARTS CENTER

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AMBULATORY SURGERY CENTER PATIENT CONSENT TO RESUSCITATIVE MEASURES

Not A Revocation Of Advance Directives Or Medical Powers Of Attorney

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This surgery center respects and upholds those rights.

However, unlike in an acute care hospital setting, the surgery center does not routinely perform "High Risk" procedures. Most procedures performed in this facility are considered to be on minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, our expected recovery and care after your surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directives or instructions from a health care surrogate or attorney-in-fact, 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 treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directives or health care power of attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current health care directive or health care power of attorney.

IF YOU DO NOT AGREE TO THIS POLICY, WE ARE PLEASED TO ASSIST YOU TO RESCHEDULE THE PROCEDURE.

Please check the appropriate box in answer to these questions. Have you executed an Advance Health Care Directive, a Living Will, a Power of Attorney that authorizes someone to make health care decisions for you?

☐ Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney.
If you checked the first box "Yes" to the question above, please provide us a copy of that document so that it may be made a part of your medical record.

☐ No, I do not have and Advance Directive, Living Will or Health Care Power of Attorney.

☐ I would like to have information on Advance Directives. Please go to www.nvlivingwill.com.

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED. IF I HAVE INDICATED I WOULD LIKE ADDITIONAL INFORMATION, I ACKNOWLEDGE RECEIPT OF THAT INFORMATION.

By: ______________________________ Witnessed By: ______________________________
(Patient's Signature) *(Witness Signature)*

Patient's Last Name:	Patient's First Name:	Date:

If consent to the procedure is provided by anyone other than the Patient, this form must be signed by the person providing the consent or authorization.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED:

By: ______________________________
(Signature)

____
(Print Name)

Relationship to Patient:

☐ Court Appointed Guardian
☐ Attorney-in-Fact
☐ Health Care Surrogate
☐ Other ____________________

Surgical Arts Center

9499 W. Charleston, Suite 250, Las Vegas, NV 89117
Phone (702) 933-3600   Fax (702) 933-3601

HIPPA NOTICE OF PRIVACY PRACTICES
Effective: May 15, 2009

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

The following notice is the privacy policy of Surgical Arts Center (SAC) as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. We are required by law to maintain the privacy of your personal health information and to provide you with this notice of our legal duties, privacy practices, your rights with respect to your personal health information and to abide by the terms of this Privacy Notice.

Your Personal Health Information
We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses and Disclosures of Your Personal Health Information
The following are the circumstances under which we are permitted by law to use and disclose your personal health information:

- **Treatment:** *Examples of treatment activities include*: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

- **Payment:** *Examples of payment activities include*: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

- **Healthcare Operations:** *Examples of healthcare operations include*: (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and give your address, phone number, insurance company name, and part of body being treated. We may also call you by name in the waiting room when your physician is ready to see you.

- **Persons Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. If you are in the hospital, we may also tell your family or friends your condition and that you are in a hospital. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Your Authorization:** Except as otherwise permitted or required as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

- **As Required by Law:** We may use or disclose your health information when we are required to do so by law.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

- **Right to Request Restrictions on Use or Disclosure:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by your agreement (except in an emergency or as required by law).

- **Right to Receive Confidential Communications:** You have the right to receive confidential communications of your personal health information. You must make your request in writing. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

- **Right to Inspect and Copy Your Personal Health Information:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance.

- **Right to Amend Your Personal Health Information**: You have the right to request that we amend your personal health information. Your request must be in writing and it must explain why the information should be amended. We have the right to deny your request for amendment under certain circumstances.

- **Right to Receive an Accounting of Disclosures of Your Personal Health Information:** Your have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

- **Right to a Paper Copy of This Notice:** You have a right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please request one from our Privacy Officer.

Complaints

You may file a complaint with us and with the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. You may submit your complaint in writing to our Privacy Officer at the address listed above. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will always have available the current notice at or near the front desk. The notice will contain, on the first page, the effective date.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to SAC. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our Privacy Officer, at the address and telephone number listed above.

I acknowledge that I have received, read and understand Surgical Arts Center's Notice of Privacy Practices.

______________________________ ________

Signature of Patient or Legal Representative Date

____

Printed Name of Patient or Legal Representative

______________________________ ________

Witness Signature Date

Surgical Arts Center
9499 W. Charleston Blvd. Suite #250
Las Vegas, NV. 89117
(702)933-3600

I acknowledge that I have received written instructions prior to my procedure of the Surgical Arts Center's policies on:

- Advanced Directives
- HIPPA Privacy policies
- Patient's Rights
- Patient's Responsibilities
- Grievance Procedures

In signing below, I fully understand these policies and have no further questions.

____ ____________
Signature of patient or legal representative Date

____
Printed Name of patient or legal representative

____ ____________
Witness signature Date

INSTRUCTION TO PATIENT: Please print or indicate by a check mark (✓) your answer to each question. These answers will greatly help your anesthesiologist to give you the best possible care during your operation. If you do not understand any question (or your answer is uncertain) simply place a question mark (?) next to the answer column.

Name ______________________ Age ________ Sex ________

Height ____________ Weight ____________ lbs. Right Handed ❑ Left Handed ❑

1. List all previous surgeries (and when).

____

____

____

____

____

	YES	NO
2. Have you or your family had a high or unexplained fever (hyperthermia) during or after surgery?	❑	❑
3. Have you or your family had any unusual reaction to anesthesia?	❑	❑
4. Have or are you taking "street drugs"?	❑	❑
5. Have you had recent weight change? (Significant amount)	❑	❑
6. Are you pregnant?	❑	❑
7. Do you smoke? If yes, ______ cigarettes per day	❑	❑
8. Do you have caps, false teeth, or contact lenses?	❑	❑
9. Do you drink alcoholic beverages How much? ____________	❑	❑

HAVE YOU OR HAVE YOU HAD . . .	YES	NO
10. Glaucoma	❑	❑
11. Stiff Jaw or Neck	❑	❑
12. A Cold in the past month	❑	❑
13. Shortness of Breath	❑	❑
14. Chronic Cough	❑	❑
15. Asthma	❑	❑
16. Heart Attack	❑	❑
17. Chest Pain; Angina	❑	❑
18. Palpitations	❑	❑
19. High Blood Pressure	❑	❑
20. Hepatitis	❑	❑
21. Hiatal Hernia	❑	❑
22. Rheumatic Fever	❑	❑
23. Ulcers	❑	❑
24. Stroke	❑	❑
25. Seizures	❑	❑
26. Blackouts	❑	❑
27. Back Problems	❑	❑
28. Muscle Disease	❑	❑
29. Arthritis	❑	❑
30. Diabetes	❑	❑
31. Thyroid Problems	❑	❑
32. Bleeding Tendencies	❑	❑
33. Sickle Cell Anemia	❑	❑
34. Blood Transfusions	❑	❑
35. Kidney Disease	❑	❑
36. Aids/HIV Positive	❑	❑
37. Any Others	❑	❑

____

____

Remarks:

Patient Label

Patient Name ______________________

Patient No. ______________________

____________ Date

______________________ Signature (Patient/or Person filling Out Form)

SURGICAL ARTS CENTER

9499 W. CHARLESTON, SUITE 250 • LAS VEGAS, NEVADA 89117

702 933-3600 fax 702 933-3601

Pre-Anesthesia Record

Surgical Arts Center
9499 W. Charleston Blvd. Suite #250
Las Vegas, NV. 89117
(702)933-3600

PATIENT'S RIGHTS

The rights of patient(s) include, but are not limited to:

1) Exercise these rights without regard to sex or cultural, economic, educational, or religious background or the source of payment for his/her care.
2) Consideration and respectful care.
3) 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 who will see him/her.
4) Receive information from his/her physician about his/her illness, course of treatment, and prospects for recovery in terms that he/she can understand.
5) Receive as much information about any proposed treatment or procedure as 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 each and to know the name of the person who will carry out the procedure or treatment.
6) Participate actively in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to refuse treatment.
7) Full consideration of privacy concerning his/her medical care program. Case 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.
8) Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the center. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
9) Reasonable responses to any reasonable requests he/she may make for service.
10) Leave the center even against the advice of his/her physicians.
11) Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing care.
12) Be advised if center/personal physician proposed to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.
13) Be informed by his/her physician or a delegate of his/her physician of his/her continuing health care requirements following his/her discharge from the center.
14) Examine and receive an explanation of his/her bill regardless of source of payment.
15) Know which center rules and policies apply to his/her conduct as a patient.
16) Have all patient's rights apply to the person who may have responsibility to make decisions regarding medical care on behalf of the patient.
17) Designate visitors of his/her choosing. If the patient has decision-making capacity, whether or not the visitor is related by blood or marriage, unless; (A) No visitors are allowed; (B) The facility reasonably determines that the presence of a particular visitor to the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility; (C) The patient has indicated to the facility staff that the patient no longer wants the person to visit.
18) Have the patient's wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity to have the method of that consideration disclosed in the center policy on visitation. At a minimum, the center shall include any person living in the household.
19) This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.
20) To file a complaint a patient should contact the Nevada State Health Bureau of Health Quality and Compliance at (702) 486-6515, 4220 South Maryland Parkway, suite 810, Las Vegas, NV, 89119. Additional resources can be found at the website: http://www.medicare.gov/Ombudsman/resources.asp

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PATIENT'S RESPONSIBILITIES

The responsibilities of the patient at this center are as follows:

1. To provide correct information on the patient registration form.
2. To advise the Center personnel of existing Advance Directives and pursuing requests and expectations
3. To provide the nursing staff with a complete health history, including allergies, surgical history and current medications.
4. To follow preparation instruction and to call with any questions or problems.
5. To bring a responsible adult driver/care giver as requested.
6. To follow the physician's post-operative instructions.

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PATIENT GRIEVANCES

POLICY:
All patient's will be informed of the grievance policy prior to the date of their procedure in both verbally and written form.
Occasionally, situations may arise that are difficult to resolve. Thus, the grievance process is available to patients who wish to have a problem formally reviewed.
The Grievance review shall begin with the person first contacted. If resolution cannot be produced by that person, the issue shall be reported to the Director of Nursing and then progress upward in the chain of command to the Administrator, Medical Director, Executive Committee, and ultimately the Board of Directors. The decision by the Board of Directors shall be final. The objective is to reach a decision that is mutually satisfactory to all parties involved.

PROCEDURE:
A patient who wished to utilize the Grievance procedure shall do so in the prescribed manner.

STEP ONE: A patient may submit a problem orally or in writing to the Center after the problem becomes known to the patient. The Center shall attempt to resolve the patient's grievance during the initial meeting. If unable to reach a mutually agreed upon settlement, the Medical Director will be notified and he/she shall investigate the situation further. In his/her best effort, a resolution shall be proposed within three (3) working days and documented in writing including the name of contact person , the steps taken to investigate grievance, the results of the grievance process and the date completed. If the patient is still not satisfied, then he/she may request a Step Two Meeting.
STEP TWO: If a patient is not satisfied with the Step One Meeting he/she may request a review by the Executive Committee. This must be done in writing within (30) days of attempted resolution by Medical Director. The Executive Committee will investigate the problem and issue a resolution to the Board of Directors within (30) days. The Board of Directors shall make final recommendation and designate a member of the Board of Directors to meet with the patient to offer resolution within (5) five working days of notification of issue. If Step Two does not resolve the problem a patient may then file an external grievance.

GRIEVANCE PROCEDURE GUIDELINES
A. Established center policy or procedure is not, itself, subject to the grievance procedure. It is only the interpretation or execution of these policies that can create a grievance.
B. Every grievance should be submitted orally or in writing within three (3) working days after the problem becomes known to the patient. A grievance which reaches Step Two must be in writing. The grievance procedure is available to all patients and visitors of the center.
C. A person may file an external grievance by filing a complaint to the Nevada State health Department at 4220 S. Maryland Parkway, suite 810, Las Vegas, NV. 89119. ph. # (702) 486-6515/ or additional resources can be found at the website : http://www.medicare.gov/Ombudsman/resources.asp
D. The Grievance Coordinator at this center will be the Medical Director.
E. All grievances making allegations of mistreatment[3], neglect[1], verbal, mental, sexual, or physical abuse[2] must be fully documented with all pertinent details including; date, time, location, names of all individuals involved and a description of the behavior that is alleged to have occurred. The grievances alleging mistreatment, neglect or abuse must be reported immediately when possible and at least on the same day.
F. In the event the allegation of neglect[1], abuse[2] or mistreatment[3] is confirmed the Nevada State Board of Nursing and the Nevada State Health Department at 4220 S. Maryland Parkway, suite 810, Las Vegas, NV 89119 will be notified

[1]Neglect: "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness (42 C.F.R. §488.301)
[2]Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 C.F.R. §488.301).
[3]Mistreatment: according to Merriam Webster dictionary "mistreatment" means to treat badly. (syn. Abuse)