HOSPITAL FOR SPECIAL SURGERY
ASC OF MANHATTAN

Effective Date: July 12, 2017

Acknowledgement of Receipt of Notice of Privacy Practices

Respect for our patients' privacy has long been highly valued at HSS ASC of Manhattan. Not only is it what our patients expect, it is the right way to conduct health care. As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices that describes the health information privacy practices of HSS ASC, its medical staff and affiliated health care providers when providing health care services for HSS ASC. Our Notice will be prominently posted in HSS ASC. You will also be able to obtain your own copy of the Notice by accessing our website at www.hss.edu/asc, calling HSS ASC at (212) 548-2510, or asking for one at the time of your next visit.

By signing below, I acknowledge that I have been provided a copy of this Notice and have therefore been notified of how health information about me may be used and disclosed by HSS ASC, and how I may obtain access to and control this information. I also acknowledge and understand that special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Date

If you have any questions about this Notice or would like further information, please contact HSS ASC's Privacy Officer at (212) 548-2510.

For Office Use Only: If the patient does not sign this acknowledgement form, record here the good faith efforts made to obtain this acknowledgement.

_____

_____

_____

This page is your copy of the acknowledgement you were asked to sign when you were first given this Notice.

HOSPITAL FOR SPECIAL SURGERY
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ADVANCE DIRECTIVES POLICY

Hospital for Special Surgery Ambulatory Surgery Center of Manhattan, LLC d/b/a HSS ASC of Manhattan (the "ASC") supports every patient's right to participate in their own health care decisions and to make advance directives or execute powers of attorney that authorize others to make decisions on their behalf when they are unable to make or communicate such decisions.

Advance directives are legal documents and instructions that govern how your health care decisions are made and notify your health care providers and others about your wishes in the event you become incapacitated and unable to make decisions on your own. New York law recognizes the following types of advanced directives:

Health Care Proxies: A health care proxy allows you to appoint a person that you trust, such as a family member or close friend, to make health care decisions on your behalf if you lose the ability to make such decisions yourself. By appointing a health care proxy you can ensure that, even in the event of unanticipated changes in your medical condition, the treatment you receive will be consistent with your wishes, values and beliefs. Your health care providers must follow the decisions made by your proxy as if they were your own.

Living Wills: A living will allows you to leave written instructions about your health care wishes. It can be used in conjunction with a health care proxy to give your proxy and health care providers additional guidance about your wishes.

Do Not Resuscitate Order ("DNR"): A DNR allows you to express that, in the event of a medical emergency, you do not wish to receive cardiopulmonary resuscitation ("CPR") to restart your heartbeat or breathing. A DNR only applies to CPR decisions and does not allow you to make written instructions about other aspects of care.

Please speak with your physician about your treatment wishes and any questions you may have about advance directives before your procedure. Please provide copies of any advance directives you may have to your physician. Advance directive forms are available at the ASC as well as on the New York State Department of Health website at www.health.ny.gov/professionals/patients/health_care_proxy/.

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PATIENT CONSENT TO RESUSCITATIVE MEASURES

As a patient, you have the right to make advance directives and change them at any time. The ASC recognizes the importance of advance directives and upholds your rights to make your own health care decisions. However, unlike in a hospital setting, the scope of services provided at the ASC is limited to elective outpatient surgeries for patients who receive medical clearance to undergo such procedures.

Therefore, it is the policy of the ASC that, regardless of the contents of any advance directive or instructions from a health care proxy, if an adverse event or medical emergency occurs during your treatment at the ASC, our professional personnel will initiate resuscitation and other stabilizing measures and will transfer you to an appropriate hospital for further evaluation. At the hospital, further treatment, or withdrawal of treatment, will be ordered in accordance with your wishes, advance directives or instructions from your health care proxy or attorney in fact.

By signing below, you (or your legal representative) acknowledge and agree that:

(i) you have read and understand this Advance Directives Policy and Patient Consent to Resuscitative Measures;

(ii) you had the opportunity to discuss the Advance Directive Policy, the Patient Consent to Resuscitative Measures, your treatment wishes and any questions you may have about advance directives with your physician before undergoing a procedure at the ASC;

(iii) you have provided your physician with a copy of any advance directives you may already have in place prior to your scheduled procedure; and

(iv) in accordance with this Advance Directive Policy and Patient Consent to Resuscitative Measures, you agree to waive any DNR and other aspects of advance directives you may have in place regarding CPR and other life-sustaining measures while you receive treatment at the ASC.

This waiver shall only apply during your treatment at the ASC and will not revoke or invalidate any DNR or other advance directive you may have in other settings. However, if for any reason you do not agree to this Patient Consent to Resuscitative Measures, the ASC will cancel your procedure and help you identify a hospital or another facility where the procedure may be performed.

PATIENT NAME: _____

SIGNATURE: _____ **DATE:** _____

If signed by a legal representative of the patient:

NAME OF REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: _____

HOSPITAL FOR SPECIAL SURGERY
ASC OF MANHATTAN

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Patient Acknowledgement

Disclosure of Physician Ownership in HSS ASC of Manhattan

Due to concerns that there may be a conflict of interest, New York State passed a law that prohibits physicians (with certain exceptions) from referring patients for clinical laboratory services, pharmacy services, x-ray or imaging services to a facility in which the physician or any of the physician's immediate family members have a financial interest. If any of the exceptions in the law apply, or if the physician is referring the patient for services other than clinical laboratory, pharmacy, x-ray or imaging services, the physician can make the referral as long as the physician discloses this financial interest and tells the patient about alternative facilities where he/she may obtain these services. This disclosure of financial interest is also required under federal law.

Thus, the following disclosure is hereby made to you, as a patient of HSS ASC of Manhattan:

> The physicians listed below are owners of, and therefore have a financial interest in, *Hospital for Special Surgery Ambulatory Surgery Center of Manhattan, LLC d/b/a HSS ASC of Manhattan*, located at 1233 Second Ave., New York, New York. This disclosure is intended to help you make a fully informed decision about your health care. For more information about alternative facilities, please ask your physician or his or her staff. They will provide you with names and addresses of providers best suited to your individual needs that are nearest to your home or place of work.

Physician Owners of HSS ASC of Manhattan

Frank Cordasco, M.D.	Lawrence Gulotta, M.D.	Anil Ranawat, M.D.
Aaron Daluiski, M.D.	Robert Hotchkiss, M.D.	Matthew Roberts, M.D.
Joshua Dines, M.D.	Lana Kang, M.D.	Scott Rodeo, M.D.
Mark Drakos, M.D.	Steve Lee, M.D.	Beth Shubin Stein, M.D.
Andrew Elliott, M.D.	David Levine, M.D.	Sabrina Strickland, M.D.
Scott Ellis, M.D.	Robert Marx, M.D.	Scott Wolfe, M.D.
Stephen Fealy, M.D.	Andrew Pearle, M.D.	

*** All of the above Physicians are also affiliated with the Hospital for Special Surgery**

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PATIENT ACKNOWLEDGEMENT

Disclosure of Physician Ownership in HSS ASC of Manhattan

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, New York State passed a law that prohibits physicians, with certain exceptions, from referring patients for clinical laboratory services, pharmacy services or x-ray or imaging services to a facility in which the physician or any of the physician's immediate family members have a financial interest. If any of the exceptions in the law apply, or if the physician is referring the patient for services other than clinical laboratory, pharmacy, or x-ray or imaging services, the physician can make the referral as long as he or she discloses this financial interest and tells the patient about alternative facilities where they may seek to obtain these services. This disclosure of financial interest is also required under federal law.

Thus, the following disclosure is hereby made to you:

> I, ANDREW D. PEARLE, M.D., am an owner of, and therefore have a financial interest in, *Hospital for Special Surgery Ambulatory Surgery Center of Manhattan, LLC d/b/a HSS ASC of Manhattan*, located at 1233 Second Ave., New York, New York. This disclosure is intended to help you make a fully informed decision about your health care. For more information about alternative facilities, please ask my staff or me. We can provide you with names and addresses of providers best suited to your individual needs that are nearest to your home or place of work.

By signing below, you (or your legal representative) acknowledge that you have read and understand the foregoing Disclosure of Physician Ownership, that the disclosure was made to you prior to the performance of any medical procedures and, after the disclosure was made, you have decided to have a medical procedure performed at HSS ASC of Manhattan.

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

If signed by a legal representative of the patient:

NAME OF REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: _____

HOSPITAL FOR SPECIAL SURGERY
ASC OF MANHATTAN

Andrew D. Pearle, MD
Tel (212) 774-2878
Fax (212) 774-2798

PHYSICIAN DISCLOSURE FORM

Tax ID 26-3381739 / NPI 142 707 1778

1. Insurance Status:

   Patient Insurance Plan _____

   Please contact your insurance to determine if Dr. Andrew D. Pearle is participating and in-network with your insurance plan using the Tax ID or NPI numbers listed above

   ___Participating ___Non-Participating

2. I am affiliated with Hospital for Special Surgery and the following hospitals:
   New York Presbyterian Hospital

3. During your procedure and/or hospital stay, we may request consultations by physicians who will also follow your case. These doctors will bill you separately.

4. We recommend that you call each provider listed to confirm their participation status with your insurance company.

   Below is a list of providers who may provide services as part of your prescribed treatment. Their contact information is also included.

Name	Address	Telephone #
East River Medical Associates* (Anesthesia Providers) **Tax ID 13-4003705**	535 East 70th Street New York, NY 10021	(844) 268-4820
Hospital for Special Surgery **Tax ID 47-1353602** **Includes: Radiology, Labs, EKG, and Pathology.**	535 East 70th Street New York, NY 10021	(212) 774-2607
Clearance MD/Medical Assessment	Varies	Varies

   ***Anesthesiology and Pathology insurance participation can also be accessed at www.hss.edu/physicians

5. Estimated charges for out-of-network services are available upon request.

6. I have been informed of the insurance participation status of the above named physician. I have reviewed the information provided to me and understand the above providers may be involved in my care.

Patient Name (PRINT) Signature Date