APPEAL

The person filing the grievance may appeal the decision of the Administrator by writing to the (Chief Executive Officer) within 15 days of receiving the Administrator's decision. The (Chief Executive Officer) shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

ACCOMMODATIONS IN THE GRIEVANCE PROCESS

The Surgery Center will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Administrator will be responsible for such arrangements.

Information for Patients and Their Families About

The Oregon Advance Directive

and Other Healthcare Decisions

BEND SURGERY CENTER

1342 NE Medical Center Drive, Suite 170
Bend, Oregon 97701
Phone (541) 318-0858
Fax (541) 318-6740

Form - F 51 06/21

ADVANCE DIRECTIVE

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decisions about your health care. Before signing, consider these important facts:

Facts About Part B (Appointing a Health Care Representative)

You have the right to name a person to direct your health care when you cannot do so. This person is called your "health care representative." You can do this by using Part B of this form. Your representative must accept on Part E of this form.

In this document, you can write any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts About Part C (Giving Health Care Instructions)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using Part C of this form.

Facts About Completing This Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this advance directive, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so.

SECTION 1557 OF THE AFFORDABLE CARE ACT GRIEVANCE PROCEDURE

It is the policy of The Bend Surgery Center not to discriminate on the basis of race, color, national origin, sex, age or disability. The Surgery Center has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for the Practice to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

SUBMISSION OF GRIEVANCE
Grievances must be submitted to the Administrator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.

A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

INVESTIGATION
The Administrator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Administrator will maintain the files and records of the Practice relating to such grievances. To the extent possible, and in accordance with applicable law, the Administrator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

The Administrator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

Informing Individuals with Limited English Proficiency of Language Assistance Services

ATTENTION: If you speak a foreign language assistance services, free of charge, are available to you. Call 541-318-0858.

Specific translations for Notice of Nondiscrimination, Statement of Nondiscrimination and Taglines are available at: http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 541-318-0858.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 541-318-0858.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 541-318-0858.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 541-318-0858.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 541-318-0858.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 541-318-0858 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 541-318-0858.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 541-318-0858 (رقم هاتف الصم والبكم: 541-318-0858.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 541-318-0858.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 541-318-0858.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 541-318-0858.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 541-318-0858.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 541-318-0858.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ 541-318-0858

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 541-318-0858.

If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes or add words that better express your wishes. Witnesses must sign PART D.

Print your NAME, BIRTHDATE AND ADDRESS here:

_____
(Name)

_____
(Birthdate)

_____

_____
(Address)

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE:

_____ My entire life
_____ Other period (_____ Years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint _____ as my health care representative. My representative's address is _____ and telephone number is _____.

I appoint _____ as my alternate health care representative. My alternate's address is _____ and telephone number is _____.

I authorize my representative (or alternate) to direct my health care when I can't do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator or employee of your health care facility, unless that person is related to you by blood, marriage or adoption, or that person was appointed before your admission into the health care facility.

1. Limits.

Special Conditions or Instructions : _____

_____

_____

INITIAL IF THIS APPLIES:
_____ I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

2. Life Support.

"Life support" refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INITIAL IF THIS APPLIES:
_____ My representative MAY decide about life support for me. (If you don't initial this space, then your representative MAY NOT decide about life support.)

3. Tube Feeding.

One sort of life support is food and water supplied artifically by medical device, known as tube feeding.

INITIAL IF THIS APPLIES:
_____ My representative MAY decide about tube feeding for me. (If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

_____ _____
(Signature of person making appointment) (Date)

NONDISCRIMINATORY POLICY
Ensures education of and public awareness of Civil Rights.
"This facility has agreed to comply with the provisions of the Federal Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act (ACA) and all requirements imposed pursuant thereto to the end that no person shall, on the grounds of race, color, national origin, ancestry, age, sex, religious creed, or disability, be excluded from participation in, be denied benefits of, or otherwise be subject to discrimination in the provision of any care or service."

CIVIL RIGHTS COMPLIANCE
The Bend Surgery Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Bend Surgery Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

COMMUNICATION ASSISTANCE
The Bend Surgery Center provides services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information if other formats can be requested and made readily available, other formats may include (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Administrator at 541-318-0858.

If you believe that that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Administrator
Bend Surgery Center
1342 NE Medical Center Drive, Suite 170
Bend, OR 97701
Phone: 541-318-0858 Email: grievances@bendsurgery.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Administrator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building, Washington, DC 20201
1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

The Bend Surgery Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

PART D: DECLARATION OF WITNESSES

We declare that the person signing this advance directive:

(a) Is personally known to us or has provided proof of identity;
(b) Signed or acknowledged that person's signature on this advance directive in our presence;
(c) Appears to be of sound mind and not under duress, fraud or undue influence;
(d) Has not appointed either of us as health care representative or alternative representative; and
(e) Is not a patient for whom either of us is attending physician.

Witnessed By:

_____ _____
(Signature of Witness/Date) (Printed Name of Witness)

_____ _____
(Signature of Witness/Date) (Printed Name of Witness)

NOTE: One witness must not be a relative (by blood, marriage or adoption) of the person signing this advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate or be employed at a health care facility where the person is a patient or resident.

PART E: ACCEPTANCE BY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document allows me to decide about that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me.

_____ _____
(Signature of Health Care Representative) (Signature of Alternate Health Care Representative)

_____ _____
(Printed Name) (Printed Name)

PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

- The terms "as my physician recommends" means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.
- "Life support" and "tube feeding" are defined in Part B above.
- If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.
- You will get care for your comfort and cleanliness, no matter what choices you make.
- You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. Close to Death. If I am close to death and life support would only postpone the moment of my death:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I DO NOT WANT tube feeding.

B. INITIAL ONE:
_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want NO life support.

2. Permanently Unconscious. If I am unconscious and it is very unlikely that I will ever become conscious again:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I DO NOT WANT tube feeding.

B. INITIAL ONE:
_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want NO life support.

3. Advanced Progressive Illness. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I DO NOT WANT tube feeding.

B. INITIAL ONE:
_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want NO life support.

4. Extraordinary Suffering. If life support would not help my medical condition and would make me suffer permanent and severe pain:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I DO NOT WANT tube feeding.

B. INITIAL ONE:
_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want NO life support.

5. General Instruction.

INITIAL IF THIS APPLIES:
_____ I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

6. Additional Conditions or Instructions. (Insert description of what you want done.)

_____
_____
_____

7. Other Documents. A "health care power of attorney" is any document you may have signed to appoint a representative to make health care decisions for you.

INITIAL ONE:
_____ I have previously signed a health care power of attorney. I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.
_____ I have a health care power of attorney, and I REVOKE IT.
_____ I DO NOT have a health care power of attorney.

SIGN HERE TO GIVE INSTRUCTIONS

_____ _____
(Signature) (Date)