Same Day Surgery Center

We want you to feel comfortable and informed about your surgery, and want your experience to be as pleasant as possible. Please feel free to call us anytime if you have questions or concerns. Our phone number is (813)783-8242.

On the day of surgery

- Please provide us with a list of all your medications; a blank form is attached for your convenience.
- Please plan to be at the surgery center 2 – 4 hours from your arrival
- A sedation medication will be given. You must arrange for transportation and be accompanied by a responsible adult. Please inform this person that our waiting room may be cold and they should dress appropriately
- Please leave all valuables at home

You will need to provide

- Insurance cards
- Drivers' license
- Method of payment
  - Cash
  - MasterCard, Visa, Discover, American Express
  - Cashiers check or money order

The surgery center will call you with your arrival time.

Surgery center fees will be reviewed with you at that time. All fees are estimates based on the information obtained from your insurance company. As the disclaimer from the insurance company states, verification is not a guarantee of benefits. **All fees are to be paid in full by noon on the Friday before surgery**. No personal checks over $500 will be accepted.

Anesthesia fees will be billed separately by Anesthesia Services.

Schedule

Procedure _____ Date_____

Dr. _____

DISCLOSURE NOTICE

Same Day Surgery Center is a Florida corporation owned by local area physicians. Your physician □ does, □ does not have ownership in this center.

A copy of the **Patient Rights and Responsibilities** is attached and prominently displayed in the surgery center waiting area.

NOTICE OF RIGHT TO EXECUTE AN ADVANCE DIRECTIVE

In the state of Florida, all patients have the right to participate in their own health care decisions. It is the policy of Same Day Surgery Center to honor patients' advance directives. It is the responsibility of the patient to provide a copy of his or her advance directive(s) to Same Day Surgery Center. If an advance directive is not available the patient will be cared for to the full extent of ACLS standards.

Same Day Surgery Center

PATIENT RIGHTS AND RESPONSIBILITIES

Every Patient Has the Right

To be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy
To an environment that is safe and secure for self and property
To confidentiality of information gathered during treatment
To prompt and reasonable response to questions and requests
To know who is providing and is responsible for his or her care
To know what patient support services are available, including whether an interpreter is available if he or she does not speak English
To know what rules and regulations apply to his or her conduct
To be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis
To refuse treatment, except as otherwise provided by law
To be given, upon request, full information and necessary counseling on the availability of know financial resources for his or her care
To know, upon request and in advance of treatment, whether the health care provider or health care practice accepts the Advance Directives
To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care
To receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have charges explained
To receive impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment
To receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment
To know if medical treatment is for purposes of experimental/research and to give his or her consent or refusal to participate in such experimental research
To express grievances regarding any violation of his or her rights, through the grievance procedure of the health care provider which served him or her

Every Patient Has the Responsibility

For providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health
For reporting unexpected changes in his or her condition to the health care provider
For reporting to the healthcare provider whether he or she comprehends a contemplated course of action and what is expected of him or her
For following the treatment plan recommended by the health care provider
For keeping appointments and when he or she is unable to do so for any reason, for notifying the Practice
For his or her actions if he or she refuses treatment or does not follow the health care provider's instructions
For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible
For following Practice rules and regulations affecting patient care and conduct
For consideration and respect of the Practice staff and property
For asking what to expect regarding pain and pain management
For providing the Same Day Surgery Center with a copy of their Advance Directive in order for it to be recognized
For providing a list of medications with doses and times along with allergies to medication and the response to that medication with each visit

If you have a complaint against this ambulatory surgical center:
Ask to speak with or call the Nurse Administrator at 813-783-8242
OR
Call or write the Agency for Health Care Administration 1-888-419-3456 (press 1) Consumer Assistance Unit 2727 Mahan Drive, Building 1 Tallahassee, Florida 32306

If you have a complaint about a health care professional:
Ask to speak with or call the Nurse Administrator at 813-783-8242
OR
Call or write the Agency of Health Care Administration 1-888-419-3456 (press 2) Consumer Services Unit P.O. Box 140000 Tallahassee, Florida 32317-4000

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman's webpage on the web at: **www.cms.hhs.gov/center/ombudsman**

Same Day Surgery Center

Medication List

Please provide a list of all medications you are taking including any over-the-counter medications and all vitamins and supplements.

Medication Name	Dose	How often	Route (by mouth, right eye, etc.)

Name_____

Date of Birth_____/_____/_____

As an accredited surgery center we must comply with certain rules and regulations set forth by Medicare and state and federal government. During the scheduling of your procedure you were given an informational packet that we are required to provide to you. By signing below you acknowledge receipt of this information.

- I have been provided a copy of my ***'Patients' Rights and Responsibilities'*** and had an opportunity to ask questions.
- I was given a ***'Medications List'*** form that I have completed with all my current medications and returned.
- I have been informed that my physician ☐ does ☐ does not have financial interest in this facility.
- I ☐ did ☐ did not provide the surgery center with an *'Advance Directive'*.

I have also been informed that:

1) **Same Day Surgery Center** 2) **The Eye Clinic of Florida** 3) **Kevin Greenwood, CRNA**

  - Are separate entities and will bill separately for services provided.

- Anesthesia services are provided by an independent provider that is not an employee of the surgery center.
- The Center will file my secondary insurance as a courtesy. However, if payment is not received within 30 days from the date of the procedure then I, the patient, will be responsible for the balance and I will contact my insurance for my own reimbursement.

I have been informed that Same Day Surgery Center may photograph and/or videotape my surgical procedure. This is used for educational purposes only. I understand that I have the right to consent or decline this type of photography.

_____ I consent to photography/video _____ I decline photography/video

The undersigned certifies that the patient has read and understands the foregoing and fully accepts the terms specified above.

✕_____ Date 04/05/2016

Patient (or Representative) Signature

Authorization for Payment

Medicare Lifetime Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Same Day Surgery Center for any services furnished to me by that physician/supplies/provider of care. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I authorize financial information and reports of my evaluation, treatment and any follow up evaluation to be sent to or discussed with my referring doctor, the doctor requesting consultation, my family physician, as well as any other healthcare providers, hospitals or outpatient facilities that I have or will identify to you.

Beneficiary's Signature_____ Date 04/05/2016

Medigap Authorization

I request that payment of authorized Medigap benefits be made on my behalf for any services furnished me by that physician. I authorize any holder of medical information about me to release to Medigap carriers any information needed to determine these benefits or the benefits payable for related services. This authorization applies to all occasions of service until it is revoked in writing by me.

Beneficiary's Signature _____ Date 04/05/2016

Insurance Authorization

I understand that I am responsible for all charges provided by the Same Day Surgery Center. I authorize release of any medical information necessary for healthcare operations, to process my insurance claims, and request payment of any benefits due to be paid directly to Same Day Surgery Center. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

Authorizing Signature _____ Date: 04/05/2016

NOTICE OF PRIVACY PRACTICES
SHORT FORM SUMMARY

This Notice is Effective as of: September 23, 2013

This is only a summary of our Notice of Privacy Practices. Please take a copy of the full Notice located in our reception area to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures.

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Marketing and Sale of PHI. We will obtain your prior written authorization before sending you certain marketing communications. We will not sell your health information.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers
- sending appointment reminders

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.
- Receive an accounting of disclosures of your PHI by our practice.
- Be notified in the case of a breach of unsecured PHI.

CONTACT US

Contact our Privacy Officer with any questions, comments, or complaints or to exercise any of your rights at:
Cassie Diehl, 813-783-8242, cdiehl@seebetterflorida.com, 6733 Gall Blvd., Zephyrhills, FL 33542.

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of **Same Day Surgery Center's** Notice of Privacy Practices effective September 23, 2013.

Name (please print): _____

Signature: _____

Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of **Same Day Surgery Center's** Notice of Privacy Practices effective September 23, 2013.

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective September 23, 2013 given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____