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**

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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_____/_____/________

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of the notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. This form is valid until your personal revocation.

I hereby acknowledge that I received the Same Day Surgery Center Medical Information Privacy Notice for my review prior to receiving services through the Same Day Surgery Center.

If there is a spouse, family member, or other person that you would like your health information released to, please fill out and sign below:

I authorize □ all my health information, □ restricted information including ______________________________ be released to the following:

1. ____ Relationship ___________________________
2. ____ Relationship ___________________________
3. ____ Relationship ___________________________

____ ______________________________

Patient (or Legal Representative) Signature Date

I have been informed by Same Day Surgery Center that:

- My insurance company will receive separate claims, and I will receive separate statements from:
  1) The surgery center 2) The physician's office 3) Anesthesia
- 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.
- My physician ☐ does ☐ does not have financial interest in this facility.
- I ☐ did ☐ did not provide the surgery center with an advance directive.

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

________________________________ ________________

Patient (or Representative) Signature Date

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 ______________

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 _______________

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 ________________

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PATIENT INFORMATION

Date_______________________________ Home Phone_________________________

Name____ Soc. Sec. #______________________________
Last Name First Name Initial

Address____
Street Address City State Zip Code

Sex □ M □ F Age_________Birthdate___________________ □ Single □ Married □ Widowed □ Separated □ Divorced

Patient Employed By____Occupation______________________________

Business Address____Business Phone______________________________

In case of emergency who should be notified?_______________________________________Phone_____________________

PRIMARY INSURANCE

Person Responsible for Account____
Last Name First Name Initial

Relation to Patient___________________________Birthdate__________________Soc.Sec.#____________________________

Address (if different from patient)____
Street Address City State Zip Code

Person Responsible Employed by____Occupation______________________

Business Address____Business Phone______________________________

Insurance Company____Soc.Sec. #______________________________

Contract #_____________________Group #____________________Subscriber_____________________________________

ADDITIONAL INSURANCE

Subscriber Name_______________________________Relation to patient__________________Birthdate_________________

Address (if different from patient)____
Street Address City State Zip Code

Subscriber Employed by______________________________________Business Phone________________________________

Insurance Company____Soc.Sec #________________________________

Contract #___________________________Group #__________________Subscriber_________________________________