MID FLORIDA ENDOSCOPY & SURGERY CENTER

PATIENT REGISTRATION FORM

Have you ever been a patient at Mid Florida Endoscopy & Surgery Center? Yes No

Patient Name: _____ _____ _____
Last First M.I.

Date of Birth: _____ Social Security Number: _____ Male Female (circle)

Complete Address: _____

_____ Home Phone ( ) _____
City, State, ZIP

Cellular Phone ( ) _____ Work Phone ( ) _____

GUARANTOR INFO ***(Complete only if you are under age 18 or incapacitated adult)***

Name of guarantor _____ Social Security # _____

Guarantor's Date of Birth _____ Relationship to Patient _____

Address (only if different than patient) _____

_____ Home Phone ( ) _____
City, State, ZIP

INSURANCE SUBSCRIBER INFO ***(Complete only if the subscriber on the insurance policy is not the patient)***

Name of Subscriber: _____ Social Security Number: _____

Relationship to Guarantor ___Spouse ___Parent ___Other Date of Birth: _____

ACCIDENT INFO ***(Complete only if the service we are providing is the result of an accident)***

Worker's Comp ____ Auto Accident____ Other____

Date of Accident or Injury (day, month, year) _____ Claim# _____

Name of Insurance carrier, claims address, phone number and name of adjuster handling the claim:

_____

_____

STATE OF FLORIDA REPORTING REQUIREMENT: The state of Florida requires health care providers to collect and report patient demographic information quarterly. One reportable item is racial classification and ethnic group. **Please circle the appropriate Classification** from the following list as supplied by the State of Florida.

RACE:

White Asian Black American Indian/Alaska Native
Native Hawaiian or Pacific Islander Other Unknown

ETHNICITY:

Hispanic Non-Hispanic Unknown

PATIENT MUST HAVE DRIVER!!

PATIENT CONSENT TO USE AND DISCLOSE HEALTH INFORMATION
For Treatment, Payment or Healthcare Operations, per HIPAA Regulations

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information is used to:

- Plan my care and treatment
- Communicate among the health professionals who contribute to my care, such as referrals
- For applying my diagnosis and treatment information to my bill
- Verify by a third party payor that services billed were actually rendered
- Assess medical quality and review competence of staff

I have been given the "*Patient Notification; Privacy Policy*" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the "*Privacy Policy*" before signing this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

REQUEST FOR RESTRICTIONS:
I request the following restrictions to the use or disclosure of my health information:

_____

MESSAGES AND REMINDERS ***(Circle yes or no for both questions)***

May we leave a message at your home using your doctor's/practice name? YES NO
May we leave a message at your work using your doctor's/practice name? YES NO

Messages will be of non-sensitive nature, such as, appointment reminders

I understand that as part of treatment, payment or health care operations, it may become necessary to disclose health information to another entity, i.e., referrals to other health care providers,. I consent to such disclosure for these uses as permitted by law.

I understand and **ACCEPT** **DELCINE** (***Circle One***) the information in this consent

_____ _____
Patient/Guardian Signature Date

_____
Print Name

If other than the patient, _____ signing, because I am the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment, or health care operations.

SURGERY CENTER OF MID FLORIDA
1950 SW 18TH Court, Suite 102, Ocala, FL 34471
352-789-6575
PATIENT NOTIFICATION

PRIVACY POLICY: At Surgery Center of Mid Florida, we recognize the sensitive nature of your personal medical information, and take every precaution to protect your privacy. When you entrust us with this information, you can be certain it will be used only within our strict guidelines. We will request the following information from your physician or surgeon. Name, address, telephone number, social security number, birthdate, guarantor demographic information, insurance information, scheduled procedure, patient's history and physical. This information is used to help us deliver the healthcare services you've requested, accurately and efficiently. Our employees are permitted access to the information they need to perform their jobs on your behalf. We maintain strict internal policies against unauthorized disclosure or use of personal medical information by employees.

RIGHTS AND RESPONSIBILITIES: Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior from you.

You (patient, patient representative, or surrogate) have the right to:

- Receive information about rights, patient conduct and responsibilities in a language and manner the patient can understand.
- Be treated with courtesy, consideration, and respect, with appreciation of his or her individual dignity.
- Be provided appropriate personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse, harassment, neglect, or mistreatment.
- Be free from any act of discrimination or reprisal.
- Voice grievances regarding treatment or care that is (or fails to be) furnished, without reprisal
- A prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his or her care.
- Know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Have a person appointed under State law to act on the patient's behalf if the patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction. If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's right to the extent allowed by State law.
- Be given by the health care provider complete information, to the degree known, concerning diagnosis, evaluation, the planned course of treatment, alternatives, risks and prognosis. When medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- To have medical records kept confidential and to access information within a reasonable time frame.
- Refuse any treatment, except as otherwise provided by law.
- Change their provider, primary provider, or specialist if other qualified providers are available.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- If eligible for Medicare, has the right to know, upon request and in advance of treatment, whether the health care provider or healthcare facility accepts the Medicare assignment rate.
- Receive, upon request, prior to treatment a reasonable estimate of charges for medical care.
- Receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Participate in decisions involving their healthcare, except when such participation is contraindicated for medical reasons.
- 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.
- Know that marketing or advertising regarding the competence and capabilities of the organization is not misleading.
- Appropriate information regarding the absence of malpractice insurance coverage.
- Express suggestions, complaints and grievances regarding any violation of his or her rights, as stated in state and federal law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- Know the facility policy on advanced directives
- To formulate advance directives and to appoint a surrogate to make healthcare decisions on his/her behalf to the extent permitted by law and provide a copy to the facility for placement in his/her medical record.
- Be informed of the names of physicians who have ownership in the facility.
- Have properly credentialed and qualified health care professionals providing patient care.

You (patient, patient representative or surrogate) are responsible for:

- Being respectful of all the health providers and staff, as well as other patients.
- Following the healthcare facility's rules and regulations affecting patient care and conduct.
- Providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, and medications, including over-the-counter products and dietary supplements, allergies or sensitivities, and other matters relating to his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- Providing a responsible adult to transport him or her from the facility and remain with him or her for 24 hours, if required by his or her health care provider.
- Following the treatment plan recommended by your health care provider.
- Informing his or her health care provider about any Living Will, Power of Attorney, or other directive that could affect his or her care.
- Keeping appointments and, where he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- His or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- Accept personal financial responsibility for any charges not covered by his or her insurance

OWNERSHIP STATEMENT: Dr. Thimmiah Kumar (1950 SW 18th Ct, 34471), Dr. Latif Hamed (3230 SW 33rd Rd, 34474), Dr. Seaborn Hunt (150 SE 17Th St, 34471), and Dr. Bheema Singu (7558 SW 61St Ave, 34476) are owners/investors in Surgery Center of Mid Florida. Dr. Ross, Dr. McNair, and Dr. Grabow, (60 SW 17Th St, 34471) also perform surgeries at this facility. Please contact their office for information regarding your choice of facilities.

ADVANCE DIRECTIVE NOTIFICATION: In the state of Florida, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power 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. Mid-Florida Endoscopy & Surgery Center respects and upholds those rights. However, unlike in an acute care hospital setting, Mid-Florida Endoscopy & Surgery Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of 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, your expected recovery, and care after surgery. Therefore, it is our policy, regardless of the contents of any Advance Directive 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 treatments or withdrawal of treatment measure already begun will be ordered in accordance with your wishes, Advance Directive, of health care Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney. If you wish to complete an Advance Directive, copies of the official state forms are available at our facility.

□Yes, I have an Advance Directive **□Yes, I have an Advance Directive, but I have no copy with me.** **□No, I do not have an Advance Directive**

Complaints

Please contact us if you have a question or concern about your rights or responsibilities.
You can ask any of our staff to help you contact the Administrator at the surgery center.

Migdalia Sanes, Administrator
1950 SW 18Th Court, Suite 102
Ocala, FL 34471
Or, you can call (352) 789-6575.

We want to provide you with excellent service, including answering your questions and responding to your concerns.

You may also choose to contact:
Accreditation Association for Ambulatory Health Care, Inc.
5250 Old Orchard Road, Suite 200
Skokie, Il 60077
1-847-853-6060
info@aaahc.org

You may also choose to contact the licensing agency of the state,
Agency for Health Care Administration
2727 Mahan Drive, Tallahassee, FL 32308
1-888-419-3456

If you are covered by Medicare, you may choose to contact the Medicare Ombudsman at 1-800-MEDICARE (1-800-633-4227) or on-line at http://www.medicare.gov/claims-and-appeals/index.html. The role of the Medicare Beneficiary Ombudsman is to ensure that Medicare beneficiaries receive the information and help you need to understand your Medicare options and to apply your Medicare rights and protections.

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED THIS DOCUMENT PRIOR TO THE START OF MY PROCEDURE.

SIGNATURE: _____ **DATE:** _____
(Patient/Patient Representative/Surrogate Signature)

Surgery Center of Mid Florida Financial Agreement

I, _____, understand that it is my responsibility to know and understand the benefits and coverage of my health plan.

As a courtesy, the Surgery Center of Mid Florida's staff will make every effort to find all information regarding my coverage, obtain any authorization needed prior to my services and submit claims to ensure full reimbursement; however, I assume all responsibilities to also contact my insurance plan and make sure services will be covered as expected.

I understand that while the insurance verification department verify all benefits, coverage, and obtain authorization the health plan does not guarantee payment and may not cover some of my services after they receive and review the claim and documentation; therefore, I will be personally responsible for any outstanding balances not handled by my insurance.

I agree to cover any co-pay at the time of my visit and submit any uncovered benefits payment within 30 days of services.

If needed, my provider (Surgery Center of Mid Florida) will provide any itemized claims at my request. If I have questions on how my insurance company paid my claim, the billing department will provide more details.

By signing this agreement, I am certifying that all of my billing information including my address and phone number on file are correct and I can be contacted if there's any questions or concerns. If I'm not available, I authorize _____ to discuss any financial information.

_____ Patient's Signature

_____/_____/_____ Date

PATIENT MUST HAVE DRIVER!!

PATIENT BILLING INFORMATION

Anesthesia is commonly a covered component of your surgery. As a courtesy, the bill/claim for anesthesia services will be filed directly to the primary insurer. We have accepted the above assignment of benefits and your insurer should send the payment directly to our address. If we have a secondary insurer on file, we may file a claim for the amount not paid by your primary insurer. If no secondary insurance was provided, we may send you a statement for the co-pay due as determined by your insurer.

In the event that Synergy Anesthesiology, Inc. is not a participating provider with your plan, we may work with your insurer(s) so that you are not penalized for our non-participating status. The amount you may owe will be within the applicable "Reasonable and Customary" benefit rate limits. We often negotiate with insurers to minimize out-of-pocket cost due to our out-of-network status. In the even that your balance is due for services defers from your explanation of benefits ("EOB") based on an adjustment by us, please contact your insurer(s) to alert them of the adjustment. It is your responsibility to contact the insurer(s) to report any adjustments applied to the patient portion due. This allows them to update their records to reflect any differences in your out-of-network deductible, out-of-pocket expenses and catastrophic cap for the benefit year.

If your insurance carrier sends payment directly to you, please contact us immediately so we may notate your account to avoid any unnecessary requests for payment. Once you reach us, we will ask that you deposit the check into your account and write a personal check for the amount of the payment you received. You will need to make the check out to Synergy Anesthesiology, Inc. and mail the check to the address above. We will also require a copy of the original EOB you received when mailing. If you have any questions or concerns, please contact our billing company at **1-888-764-0092**. You may also contact our Administrative Office at **1-888-728-0882 extension 111 or extension 1**. Please ask any questions that you may have so the content of this letter is understood at the time of service.

You will receive an EOB from your carrier until a statement is received by you from Synergy Anesthesiology, Inc. Please do not make any payments to us until you are notified in writing.

ASSIGNMENT OF BENEFITS

Synergy Anesthesiology, Inc.
PO Box 4380
Alpharetta, Georgia 30023

I _____ **(INITIALS)** with insurance benefits through_____ **(EMPLOYER NAME IS APPLICABLE)** _____ **(MEDICARE, MEDICAID, INDIVIDUAL or GROUP PLAN)** hereby authorize benefits to be assigned to Synergy Anesthesiology, Inc. **("PROVIDER"),** for healthcare services rendered to me, or to the patient for whom I am a Guardian, if applicable, by Provider, pursuant to Fla. Stat. § 627.422, and all other applicable state and federal law. I certify that the information identified herein is true and accurate as of the date of service and that I am responsible for keeping it updated. I am aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I understand that my insurer may not pay 100% of the medical claim, and I may be responsible for any amounts not payable by my insurer, including any portion paid and not applied to in-network benefits for any out-of-network services

I authorize Providers to submit claims on my behalf to the insurance company providing my benefits, under nay applicable plans held in my name or for my benefits. I hereby instruct and direct my Insurer to pay **ALL** plan benefits directly to the Provider for **ALL** services rendered. I understand under applicable state and federal law that I have the right and authority to direct where payment for service rendered be sent. If my current policy prohibits direct payment to the provider of service, I hereby instruct my Insurer to issue a check directly to the Provider, mailed to the address listed above, or otherwise designated by Provider for payment. Said check shall be made payable to me as payment towards the total charges for the professional services rendered by Provider. Upon receipt of said check, I authorize provider to endorse "for deposit only," and to deposit and apply all proceeds towards payment of my account. This authorization includes any and all rights permissible, including all rights of appeal, disclosures, administrative reviews, litigation on my behalf and remedies due to any applicable state or federal law, or plan language provision.

I authorize the release or any information pertinent to my case to any insurer, adjuster, government agency, or attorney as may be required to enforce my rights and the rights of Provider here under. A copy of this Assignment shall be treated as an original. I have read and understand the forgoing, and hereby authorize thee Provider to provide medical care that is reasonable and at the standard of care as required by state law, and as set forth herein.

PATIENT NAME:	**PATIENT SIGNATURE:**
POLICY HOLDER NAME: ***(IF DIFFERENT FROM PATIENT)***	**PARENT/GAURDIAN SIGNATURE:** ***(IF APPLICABLE)***
INSURANCE COMPANY: ***(POLICY NUMBER)***	**DATE:**