Completing Your Online Patient Pre-Registration
Safety Harbor Surgery Center
3280 N. McMullen Booth Road, Suite 110, Clearwater, FL 33761
(727) 787-3000

Safety Harbor Surgery Center offers patients the convenience and privacy of a secure, online registration process. If you are a new patient to our center, please go online today to complete your registration using the login information below. You will be asked about your health history, medications, and previous surgeries. It’s important to complete your online registration as soon as possible so that your medical team will have time to review your information prior to your visit. We will call you if we have any questions or concerns.

You will be receiving an automated recorded message from Simple Admit when your appointment is scheduled. If you are unable to understand or write down the information from this message please call (727) 787-3000.

Here are the simple steps for completing the online pre-visit medical screening and registration form:

2. Select “Simple Admit” on left side of home page.
3. Scroll to the middle of the page and enter the following password: SHSC727NEW
4. Please review our policies and enter your medical history as soon as possible.

**IF THIS IS YOUR FIRST VISIT TO SAFETY HARBOR SURGERY CENTER OR IT HAS BEEN LONGER THAN A YEAR SINCE YOUR LAST VISIT YOU WILL NEED TO COMPLETE THE PRE-VISIT MEDICAL SCREENING AND REGISTRATION ONLINE WITH ANY COMPUTER, TABLET OR SMART PHONE.**

*If you are unable to go online please fill out your Guest Registration Packet and contact our pre admission testing nurse at (727) 787-3000.* Please have your medical history information available to assist the nurse with your medical screening. Thank you in advance for completing your online registration. This information will help us give you the best medical care possible. We look forward to seeing you soon!
Guest Registration Information

Have you ever been a patient at the Safety Harbor Surgery Center in the past?  YES  NO

Patient Name: ____________________________  ____________________________  ____________________________
  Last  First  M.I.  Male  Female

Date of Birth: ____________________________  Soc. Security Number: ____________________________

Complete Address: ____________________________________________________________

City, State, ZIP

Cellular Phone # ( ) ____________________________  Work Phone # ( ) ____________________________

Email: ____________________________________ (This will only be used for your online patient satisfaction survey)

Race: (circle one)  Black  White  Asian  Hispanic  Other ____________________________

(For our female guests)
Is there a chance that you may be pregnant?  YES  NO

Last menstruation Period ____________________________  Estimated Due Date ____________________________

** GUARANTOR INFO (ONLY complete if the patient is a minor (under 18 yrs) or incapacitated adult)**

Name of Guarantor ____________________________  Soc Security # ____________________________

Guarantor’s Date of Birth ____________________________  Relationship to patient ____________________________

Address (only if different than patient) ____________________________________________________________

City, State, Zip

** INSURANCE SUBSCRIBER INFO (complete ONLY if sub on the insurance policy is not the patient)**

AName of Subscriber ____________________________  Soc. Security # ____________________________

Relationship to Guarantor  ___ Spouse  ___ Parent  ___ Other  Date of Birth ____________________________

** ACCIDENT INFO (please complete if service we are providing to you today 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: ____________________________

________________________________________________________

REV 01.15.2019
Medicare Secondary Payer Questionnaire
(Short Form)

1. Are you receiving benefits from any of the following programs?
   - Black Lung  _____ No  _____ Yes
   - Research Grant  _____ No  _____ Yes
   - Veteran Affairs  _____ No  _____ Yes

2. Was the illness/injury due to a work related accident/condition?
   _____ No  _____ Yes
   Date of injury/illness: ______________________

3. Was illness/injury due to a non-work related accident?
   _____ No  _____ Yes
   Date of accident: ______________________
   What type of accident caused the illness/injury?
   _____ Automobile  _____ Non-automobile

4. Are you entitled to Medicare based on:
   _____ Age  _____ Disability  _____ End Stage Renal Disease

5. Are you currently employed?
   _____ No  _____ Yes

6. Is your spouse currently employed?
   _____ No  _____ Yes

7. Do you have group health plan (GHP) coverage based on your own, or a spouse’s, current employment?
   _____ No  _____ Yes

8. Does the employer that sponsors your GHP employ 20 or more employees?
   _____ No  _____ Yes

9. Are you currently a patient in a skilled nursing facility such as a nursing home?
   (Long form not required. ALERT: If yes, bill SNF not Medicare)
   _____ No  _____ Yes

I confirm that the above information is correct.

Patient Signature:_________________________  Date:____________________

Please Print Name:_________________________
Patient’s Communication Preferences Regarding their PHI

**Telephone Communication Preferences**

Home #
Work #
Mobile #
Other

**E-Mail Communication Preferences**

Email Address

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Safety Harbor Surgery Center or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, Safety Harbor Surgery Center or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

**Mail Communication Preferences**

May we send mail to your home address? *(If no, please provide an alternate mailing address below.)*

**Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)*

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I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

Patient or Personal Representative Signature

Date

Printed Name

Relationship to Patient
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who Presents this Notice

This Notice describes the privacy practices of United Surgical Partners International (the “Facility”) and members of its workforce, as well as the physician members of the medical staff and allied health professionals who practice at the Facility. The Facility and the individual health care providers together are sometimes called "the Facility and Health Professionals" in this Notice. While the Facility and Health Professionals engage in many joint activities and provide services in a clinically integrated care setting, the Facility and Health Professionals each are separate legal entities. This Notice applies to services furnished to you at Safety Harbor Surgery Center, 3280 McMullen Booth Road, Suite 110 Clearwater, Florida 33761, as a Facility and all off-campus outpatient departments as an inpatient or outpatient in a Facility-affiliated program involving the use or disclosure of your health information.

Privacy Obligations

The Facility and Health Professionals each are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. The Facility and Health Professionals use computerized systems that may subject your Protected Health Information to electronic disclosure for purposes of treatment, payment and/or health care operations as described below. When the Facility and Health Professionals use or disclose your Protected Health Information, the Facility and Health Professionals are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

Notifications

The Facility is required by law to protect the privacy of your medical information, distribute this Notice of Privacy Practices to you, and follow the terms of this Notice. The Facility is also required to notify you if there is a breach or impermissible access, use or disclosure of your medical information.

Permissible Uses and Disclosures Without Your Written Authorization

In certain situations your written authorization must be obtained in order to use and/or disclose your PHI. However, the Facility and Health Professionals do not need any type of authorization from you for the following uses and disclosures:

**Uses and Disclosures for Treatment, Payment and Health Care Operations.** Your PHI may be used and disclosed to treat you, obtain payment for services provided to you and conduct “health care operations” as detailed below:

**Treatment.** Your PHI may be used and disclosed to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, you may be contacted to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be available to you.
of interest to you. Your PHI may also be disclosed to other providers involved in your treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because if you do, this may impact your recovery.

**Payment.** Your PHI may be used and disclosed to obtain payment for services provided to you—for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care (“Your Payor”) to verify that Your Payor will pay for health care. The physician who reads your x-ray may need to bill you or your Payor for reading of your x-ray therefore your billing information may be shared with the physician who read your x-ray.

**Health Care Operations.** Your PHI may be used and disclosed for health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you. For example, PHI may be used to evaluate the quality and competence of physicians, nurses and other health care workers. PHI may be disclosed to the Facility Compliance & Privacy Office in order to resolve any complaints you may have and ensure that you have a comfortable visit. Your PHI may be provided to various governmental or accreditation entities such as the Joint Commission on Accreditation of Healthcare Organizations to maintain our license and accreditation. In addition, PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of the Facility and Health Professionals.

Additionally, your PHI may be used or disclosed for the purpose of allowing students, residents, nurses, physicians and others who are interested in healthcare, pursuing careers in the medical field or desire an opportunity for an educational experience to tour, shadow employees and/or physician faculty members or engage in a clinical Practicum.

**Health Information Organizations.** Your PHI may be used and disclosed with other health care providers or other health care entities for treatment, payment and health care operations purposes, as permitted by law, through a Health Information Organization. A list of Health Information Organizations in which this facility participates may be obtained upon request or found on the facility’s website at http://safetyharborsurgerycenter.com/. For example, information about your past medical care and current medical conditions and medications can be available to other primary care physicians or hospitals, if they participate in the Health Information Organization. Exchange of health information can provide faster access, better coordination of care and assist providers and public health officials in making more informed treatment decisions. You may opt out of the Health Information Organization and prevent providers from being able to search for your information through the exchange. You may opt out and prevent your medical information from being searched through the Health Information Organization by completing and submitting an Opt-Out Form to the registration.

**Use or Disclosure for Directory of Individuals in the Facility.** Facility may include your name, location in the Facility, general health condition and religious affiliation in a patient directory without obtaining your authorization unless you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or minister, even if they do not ask for you by name. If you do not wish to be included in the facility directory, you will be given an opportunity to object at the time of admission.

**Disclosure to Relatives, Close Friends and Other Caregivers.** Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you who is involved in your health care or helps pay for your care. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the Facility and/or Health Professionals may exercise professional judgment to determine whether a disclosure is in
your best interests. If information is disclosed to a family member, other relative or a close personal friend, the Facility and/or Health Professionals would disclose only information believed to be directly relevant to the person’s involvement with your health care or payment related to your health care. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Health Oversight Activities. Your PHI may be disclosed to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. For example, your PHI may be disclosed to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the facility.

Correctional Institution. Your PHI may be disclosed to a correctional institution if you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain requests to us.

Organ and Tissue Procurement. Your PHI may be disclosed to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Research. Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board approves a waiver of authorization for disclosure.

Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to a person’s or the public’s health or safety.

U.S. Military. Your PHI may be use or disclosed to U.S. Military Commanders for assuring proper execution of the military mission. Military command authorities receiving protected health information are not covered entities subject to the HIPAA Privacy Rule, but they are subject to the Privacy Act of 1974 and DoD 5400.11-R, "DoD Privacy Program," May 14, 2007.

Other Specialized Government Functions. Your PHI may be disclosed to units of the government with special functions, such as the U.S. Department of State under certain circumstances for example the Secret Service or NSA to protect the country or the President.
Workers’ Compensation. Your PHI may be disclosed as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of a medical device.

Appointment Reminders. Your PHI may be used to tell or remind you about appointments.

Fundraising. Your PHI may be used to contact you as a part of fundraising efforts, unless you elect not to receive this type of information.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Use or Disclosure with Your Authorization. For any purpose other than the ones described above, your PHI may be used or disclosed only when you provide your written authorization on an authorization form (“Your Authorization”). For instance, you will need to execute an authorization form before your PHI can be sent to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

Marketing. Your written authorization (“Your Marketing Authorization”) also must be obtained prior to using your PHI to send you any marketing materials. (However, marketing materials can be provided to you in a face-to-face encounter without obtaining Your Marketing Authorization. The Facility and/or Health Professionals are also permitted to give you a promotional gift of nominal value, if they so choose, without obtaining Your Marketing Authorization). The Facility and/or Health Professionals may communicate with you in a face-to-face encounter about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without Your Marketing Authorization.

In addition, the Facility and/or Health Professionals may send you treatment communications, unless you elect not to receive this type of communication, for which the Facility and/or Health Professionals may receive financial remuneration.

Sale of PHI. The Facility and Health Professionals will not disclose your PHI without your authorization in exchange for direct or indirect payment except in limited circumstances permitted by law. These circumstances include public health activities; research; treatment of the individual; sale, transfer, merger or consolidation of the Facility; services provided by a business associate, pursuant to a business associate agreement; providing an individual with a copy of their PHI; and other purposes deemed necessary and appropriate by the U.S. Department of Health and Human Services (HHS).

Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law require special privacy protections for certain highly confidential information about you (“Highly Confidential Information”), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental illness, mental retardation and developmental disabilities; (3) is about alcohol or drug abuse or addiction; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about communicable disease(s), including venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult; or (9) is about sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION
**Right to Request Additional Restrictions.** You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, the Facility and Health Professionals are not required to agree to these requested restrictions.

You may also request to restrict disclosures of your PHI to your health plan for payment and healthcare operations purposes (and not for treatment) if the disclosure pertains to a healthcare item or service for which you paid out-of-pocket in full. The Facility and Health Professionals must agree to abide by the restriction to your health plan EXCEPT when the disclosure is required by law.

If you wish to request additional restrictions, please obtain a request form from the Health Information Management Office and submit the completed form to the Health Information Management Office. A written response will be sent to you.

**Right to Receive Confidential Communications.** You may request, and the Facility and Health Professionals will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

**Right to Revoke Your Authorization.** You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the Facility and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Facility Health Information Management Office identified below.

**Right to Inspect and Copy Your Health Information.** You may request access to your medical record file and billing records maintained by the Facility and Health Professionals in order to inspect and request copies of the records. Under limited circumstances, you may be denied access to a portion of your records. If you desire access to your records, please obtain a record request form from the Facility Health Information Management Office and submit the completed form to the Facility Health Information Management Office. If you request copies of paper records, you will be charged in accordance with federal and state law. To the extent the request for records includes portions of records which are not in paper form (e.g., x-ray films), you will be charge the reasonable cost of the copies. You also will be charged for the postage costs, if you request that the copies be mailed to you. However, you will not be charged for copies that are requested in order to make or complete an application for a federal or state disability benefits program.

**Right to Amend Your Records.** You have the right to request that PHI maintained in your medical record file or billing records be amended. If you desire to amend your records, please obtain an amendment request form from the Facility Health Information Management Office and submit the completed form to the Facility Health Information Management Office. Your request will be accommodated unless the Facility and/or Health Professionals believe that the information that would be amended is accurate and complete or other special circumstances apply.

**Right to Receive an Accounting of Disclosures.** Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, you will be charged for the accounting statement.
Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Facility Compliance & Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Facility Compliance & Privacy Office will provide you with the correct address for the Director. The Facility and Health Professionals will not retaliate against you if you file a complaint with the Facility Privacy Office or the Director.

Effective Date and Duration of This Notice

Effective Date This Notice is effective on December 1, 2018.

Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that the Facility and Health Professionals maintain, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas around the Facility and on our Internet site at http://safetyharborsurgerycenter.com/. You also may obtain any new notice by contacting the Facility Compliance & Privacy Officer.

FACILITY CONTACTS:

Safety Harbor Surgery Center
Compliance & Privacy Office
Attn: Privacy Officer
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
E-mail: PrivacySecurityOffice@tenethealth.com
Ethics Action Line (EAL): 1-800-8-ETHICS
**NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT**

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient’s personal representative.

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**FOR INTERNAL USE ONLY**

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If applicable, reason patient’s written acknowledgment could not be obtained:

- [ ] Patient was unable to sign.
- [ ] Patient refused to sign.
- [ ] Other ______________________

_5 (Version: As noted on NPP) 1/1/2017 (Date: As noted on NPP)
PATIENT RIGHTS

Receive access to equal medical treatment and accommodations regardless of race, creed, sex, national origin, religion or sources of payment for care.

Be fully informed and have complete information, to the extent known by the physician, regarding diagnosis, evaluation, treatment, procedure and prognosis, as well as the risks, side effects, and expected outcomes associated with treatment and procedure prior to the procedure.

To give or withhold informed consent, participate in making decisions about his/her care, treatment or services.

Exercise his or her rights without being subjected to discrimination or reprisal.

Voice grievances regarding treatment or care that is (or fails to be) provided.

Personal privacy.

Receive care in a safe setting and be treated with dignity.

Be free from all forms of abuse, exploitation, or harassment.

Receive the care necessary to regain or maintain his or her maximum state of health and if necessary, cope with death.

Receive notice of their rights prior to the surgical procedure in verbal and written notice in a language and manner that ensures the patient, or the patient’s representative, or the patient’s surrogate understand all of the patient’s rights.

Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience, as well as perform the services for which they are responsible with the highest quality of services.

Be fully informed of the scope of services available at the facility, provisions for afterhours care and related fees for services rendered.

Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient’s rights shall be exercised by the patient’s designated representative or patient’s surrogate other legally designated person.

Make informed decisions regarding his or her care.

Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions including refusal of treatment or not following the instructions of the physician or facility.

Approve or refuse the release of medical records to any individual outside the facility, or as required by law or third party payment contract.

Be informed of any human experimentation or other research/educational projects affecting his or her care of treatment and can refuse participation in such experimentation or research without compromise to the patient’s usual care.

Express grievances/complaints and suggestions at any time and to have those reviewed by the organization. Access to and/or copies of his/her medical records.

Be informed as to the facility’s policy regarding advance directives/living wills.

Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the patient transfer.

Express those spiritual beliefs and cultural practices that do not harm or interfere with the planned course of medical therapy for the patient.

Expect the facility to agree to comply with Federal Civil Rights Laws that assure it will provide interpretation for individuals who are not proficient in English.

Have an assessment and regular assessment of pain.

Education of patients and families, when appropriate, regarding their roles in managing pain.

Created For USPI Affiliated Facilities

- 1 -
To change providers if other qualified providers are available. If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient’s behalf. If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state laws may exercise the patient’s rights to the extent allowed by state law.

**PATIENT RESPONSIBILITIES**

Be respectful and considerate of other patients and personnel and for assisting in the control of noise, eating and other distractions.

Respecting the property of others and the facility.

Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.

Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.

Providing care givers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, including over-the-counter products and dietary supplements, any allergies or sensitivities, unexpected changes in the patient’s condition, or any other patient health matters.

Follow the treatment plan prescribed by his/her provider and participate in his/her care.

Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider.

Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeit of care at the facility.

Promptly fulfilling his or her financial obligations to the facility and accept personal financial responsibility for any charges not covered by his/her insurance.

Identifying any patient safety concerns.

**ADVANCE DIRECTIVE NOTIFICATION**

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers 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. Safety Harbor Surgery Center respects and upholds those rights.

Our team is dedicated to delivering the highest quality care in a safe environment that places the patient at the center of our care. We respect your rights to participate in make decisions regarding your care and self determination and will carefully consider your requests. After careful consideration and reviewing the applicable state regulation (Florida), the leadership of the facility has established a policy to initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. The majority of procedures performed at Safety Harbor Surgery Center are considered to be of minimal risk, hence the risk of you needing such measures are highly unlikely. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive, or health care power of attorney.
You have the option of proceeding with care at our facility or having the procedure at another location that may not set the same limitations. Having been fully informed of our Statement of Limitations, you choose to proceed with your procedure at Safety Harbor Surgery Center.

Patient Signature_________________________________ Date__________

If you wish to complete an Advance Directive, copies of the official State forms are available at our facility.

If you do not agree with this facility’s policy, we will be pleased to assist you in rescheduling your procedure.

PATIENT COMPLAINT OR GRIEVANCE

To report a complaint or grievance you can contact the facility Administrator by phone at 727-787-3000 or by mail at:

Safety Harbor Surgery Center 3280 North McMullen Booth Road, Suite 110 Clearwater, FL 33761-2009

Complaints and grievances may also be filed through:

Agency For Health Care Administration 2727 Mahan Drive, Tallahassee, FL 32308 1-888-419-3456

Medicare beneficiaries may receive information regarding their options under Medicare and their rights and protections by visiting the website for the Office of the Medicare Beneficiary Ombudsman at: (1-800-633-4227) or:

Report a Patient Safety or Quality of Care Event:
Office of Quality and Patient Safety The Joint Commission One Renaissance Boulevard Oakbrook, Illinois 60181 Email: patientsafetyreport@jointcommission.org Fax: 630-792-5636 https://apps.jointcommission.org/QMSInternet/IncidentEntry.aspx
Submit and update your concern with your incident number:
https://apps.jointcommission.org/QMSInternet/IncidentUpdate.aspx

Created For USPI Affiliated Facilities
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Safety Harbor Surgery Center, LLC
Patient Agreement and Consent

1. CHOICE IN HEALTHCARE FACILITIES: You have healthcare choices. These are a few alternative facilities available to you:

Mease Countryside Hospital  
Mease Dunedin Hospital  
Morton Plant Hospital  
3231 McMullen Booth Road  
601 Main Street  
300 Pinellas Street  
Safety Harbor, Florida 34695  
Dunedin, Florida 34698  
Clearwater, Florida 33756  
(727) 725-6111  
(727) 733-1111  
(727) 462-7000

2. CONSENT TO TREATMENT: I hereby authorize the physician in charge of my care the Surgery Center to provide services including, but not limited to, emergency medical services, routine, diagnostic procedures, and medical procedures as their judgment may deem necessary or advisable. I acknowledge that any physicians and surgeons furnishing services to me including, but not limited to, radiologists, anesthesiologists, and pathologists are independent contractors with me and are not employees, agents or servants of the Surgery Center. I further understand that I am under the care and supervision of my surgeon and that it is my surgeon’s sole responsibility to obtain my informed consent when required for medical, surgical, diagnostic, or therapeutic procedures, or facility services rendered to me under the general or special instructions of my surgeon.

3. AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize the Surgery Center and/or any treating physicians, and my insurance company to obtain, or my attorney, use and/or release information (current and historical) for the purposes of treatment, payment, and/or operations, as outlined in the Notice of Privacy Practices. This may include collection agencies, credit bureaus, and myself, and will be limited to the minimum amount necessary.

4. MEDICARE/ MEDIGAP/ MEDICAID PATIENT CERTIFICATION/ RELEASE OF INFORMATION AND PAYMENT REQUEST: I certify that the information given to apply for payment under Title XVIII and/or Title XIX, of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare, Medigap or Medicaid for payment. I understand that I am responsible for any health insurance deductibles and co-payments.

5. ASSIGNMENT OF INSURANCE BENEFITS AND GUARANTEE OF PAYMENT: I hereby authorize, request and direct any and all assigned insurance companies to pay directly to the Surgery Center and/or my treating physician the amount due me in my pending claims for facility benefits under the respective policies. For value received, including but not limited to the services rendered, I agree to guarantee and promise to pay the Surgery Center and any treating physicians, all charges and expenses incurred in my treatment, including those expenses not covered by any insurance policy presently in force, including any co-payment and/or deductible. I understand that the Surgery Center will provide me with an
estimate of charges prior to my procedure. Unless specifically agreed in writing, all charges shall be paid prior to your procedure. Unpaid accounts shall bear interest at the rate provided by law, whether suit is brought or appeal taken. If any action at law or in equity is brought to enforce this agreement, the facility and/or treating physicians shall be entitled to recover attorney’s fees, court costs, and any other costs of collection incurred.

6. **RELEASE OF RESPONSIBILITY AND LIABILITY FOR PERSONAL VALUABLES:**

I understand that the Surgery Center discourages retaining personal valuables while at the center and agree that the Surgery Center is not responsible for valuables or belongings brought into the facility. Personal valuables or belongings include, but are not limited to, clothing, dentures, glasses, prosthetic devices (such as hearing aids, artificial limbs, or assist devices such as: canes, walkers, or wheelchairs), credit cards, jewelry and money.

7. Your physician may be an owner in Safety Harbor Surgery Center, LLC. Owners include: Dr. Umesh Choudhry; Dr. Dana Deupree; Dr. Theodore Small; Dr. Robert Davidson; Dr. Satinderpal Sondhi; Dr. Gourisankar Degala; Dr. Michael Manning; Dr. Robert Roth; Dr. Aaron Davis; Dr. Lee Ann Brown and Dr. George Panagakos.

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS DOCUMENT HAS BEEN READ BY OR EXPLAINED TO ME AND I UNDERSTAND THIS INFORMATION. I WILL RECEIVE A COPY OF THIS DOCUMENT UPON REQUEST. I ACKNOWLEDGE THAT A COPY OF THIS DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.

Patient Signature: ___________________________ Date: ___________________________

Signature of Patient’s Authorized Representative: ___________________________

Relationship to Patient: ___________________________

Surgery Center Representative: ___________________________
Where do I go the day of surgery?
Safety Harbor Surgery Center. The physical address is as follows:
3280 North McMullen Booth Road
Suite 110
Clearwater, Florida 33761
Phone: 727.787.3000 for directions.

The surgery center is on the 1st floor of a two-story building. The suite is 110, just to the left as you come through the main entrance of the building. The receptionist is just inside the surgery center entrance. Our hours of operation are from 7:00 am to 5:00 pm.

How late can I eat or drink before my surgery? Can I brush my teeth the morning of my procedure?
Your physician or a pre-operative nurse will inform you of eating and drinking restrictions prior to surgery. It is very important that you follow the provided instructions. If you do not, your surgery may be delayed or cancelled. You should also refrain from chewing gum and smoking. You may brush your teeth but do not swallow.

Do I take my medication the morning of the procedure?
Take your blood pressure medication if not a diuretic, heart medication, thyroid medication, steroid medication and anti-seizure medication the morning of surgery before you come to the surgery center with a small sip of water. If you take insulin, you should take half the dose of the insulin the morning of surgery (unless told otherwise by your doctor).

What should I bring with me and what should I wear to the surgery center?
Bring only what is needed for your comfort and only what is requested by the facility. Wear clothing that is easy to slip on and off. Consider bringing a sweater if you are easily chilled. Unless you have a financial responsibility, leave money and credit cards home. Leave all jewelry (includes body piercings) and other valuables at home. If you wear dentures or hearing aids, you may wear them to the surgery center; however, you may be asked to remove them before your procedure. Refrain from perfume or cologne as it may affect other patients that may be sensitive to the smells.

What will happen once I go to the area to prepare for my procedure?
You will be taken to an area called pre-op. Here you may change into a gown. You will be place stretcher or in a chair in your own area with curtains to help protect your privacy. You will be attached to a monitor to observe your blood pressure, heart rate, respirations and temperature. Your pre-op nurse will review your health history, medications, allergies, the procedure you are having and the name of your physician. These questions will be asked by all your healthcare providers prior to your procedure. This will be of a repetitive nature. This is not to annoy but to protect you from harm. Once settled by your nurse in pre-op, you will then meet your anesthesia and operating room team.

Your pre-op nurse will complete the necessary documents with you to get you ready. You may have an intravenous (IV) line started before you are taken to your procedure. The IV is inserted into your vein using a needle inside a small soft tube and attached to a line with a bag of fluid. The fluid used is water with nutrients. If your procedure requires anesthesia, your medications will be given through your IV. Once you are prepared, you will be taken into the operating room.

What happens when I go to the Operating or Procedure Room?
You will be taken into the operating room by your team and you may be asked to move to another bed in the room. You will receive warm blankets. An anesthesiologist or certified registered nurse anesthetist (CRNA) under the supervision of a physician, will place the monitor leads on you, provide you with oxygen through a plastic tube under your nose, and give you medications through your IV to make you relax or sleep. You will be told when this happens. Once your procedure is finished, you will be taken to the recovery room.
What happens in the recovery room?
After you wake up, you may stay in recovery 15 to 60 minutes or longer, depending on your needs, or you may recover in a recliner for 15-30 minutes. Let the nurse know if you experience any pain or nausea. You will be given something to drink to check your tolerance of fluids. Your nurse will review with you and a family member your discharge instructions written by your doctor, for you at home. This is the time to ask any questions. A member of the staff will call you the next day to see how you are feeling.

Can visitors come with me?
Yes, visitors are welcome. Before surgery, visitors will be asked to wait in the lobby until you are settled in the pre-op area and then will be allowed to stay with you until you go in for your procedure. The number of visitors allowed is determined by the nursing staff. During your procedure, visitors will be asked to wait in the waiting room.

Can I drive myself home after my procedure?
No. You will need to arrange for someone to drive you home. You will also need to arrange to have a caregiver with you for 24 hours after your procedure. If you need assistance with transportation you may call the center prior to the day of your procedure for assistance with this. Uber transportation is not permitted.

If you have any questions regarding surgery preparation, please call the surgery center at 727.787.3000.

If you have any questions regarding your procedure, prescriptions, or after care instructions, please contact your physician.

If you have a medical emergency once you are discharged home, please immediately pick up the phone and call 9-1-1.

What costs will I incur for my procedure?
You will receive an estimate of the amount due for the facility fee based off your insurance benefits, which is due at time of service. Insurance Disclaimer: “A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member’s contract at time of service.”

You may also receive additional bills from the surgeon’s office, the anesthesia group, pathology, physician assistant and/or medical supply companies.

Please be advised that Anesthesia Management Solutions may not be contracted with your insurance carrier. Please call 1-877-822-6281 to verify if they are participating with your insurance prior to your scheduled procedure.

Updated 12/17/2018
For Anesthesia billing questions, contact Bolder Billing Services at 1-877-822-6281.

Dear Safety Harbor Surgery Center Patient,

Anesthesia is commonly a covered component of your surgery. As a courtesy to you, the bill/claim for your anesthesia services will be filed directly to your primary insurance carrier, then to your secondary insurance carrier after primary payment. If no secondary insurance was provided at the time of service, we will send you a statement for the co-insurance due as determined by your insurance carrier. We have accepted assignment of benefits and your insurance carrier should send the payment directly to our remittance address.

If your insurance carrier sends payment directly to you, please endorse the back of the check and list “Pay to the order of AMS above your signature OR write a personal check for the amount received payable to AMS. Please forward payment to the name and address listed above. We also request that you send a copy of the original explanation of benefits received from your insurance company if they send payment directly to you.

AMS may not be a participating provider with your insurance company. However, we will usually be able to secure less out of pocket expense on your behalf through appeal efforts with your insurance company than if we were a participating provider, and will calculate any remaining patient liability after your insurance company processes your claim by applying a minimum reimbursement expectation. This means that we expect to receive a minimum of $250 for our services, and you will only be billed if your insurance company pays less than that amount. If we receive more than that minimum amount, which is nearly always the case, you will have zero out of pocket expenses for your anesthesia services.

Please read and ask any questions that you may have so the content of this letter is understood at the time of service.

Please retain a copy of this letter for your records in case you need to contact us while the claim is being processed and until it has been satisfied. You will receive an explanation of benefits from your carrier and until a statement is received by you from AMS, please do not make any payments to us until you are notified in writing. If you have any questions about anesthesia billing upon receipt of an explanation of benefits from your insurance, please contact us at the number above. It is important to know that the explanation of benefits you receive from your insurance is not a bill. If you are paid directly by your carrier please contact us immediately.

Assignment of Benefits and Authorization to Appeal: I authorize payment of medical benefits to AMS. It is my understanding that the only charges that I may be responsible for are those charges assigned as “patient responsibility” by my insurance company or other third party payer or when I have no insurance or third party coverage. I agree to immediately remit to AMS any payments that I receive directly for services provided. I hereby authorize release of any medical records or information necessary to process insurance claims, appeal benefit determinations, coverage denials, or other adverse decisions on my behalf.

HIPAA Notice: Please note that AMS and Safety Harbor Surgery Center are Business Associates. As a result, AMS may receive, use, obtain, access or create Protected Health Information from or on behalf of Safety Harbor Surgery Center in the course of providing anesthesia service. In order to insure your privacy and protection, please carefully read the HIPAA information AMS and Safety Harbor Surgery Center have provided.