Lake Mary Surgery Center

PATIENT INFORMATION SHEET

Patient Name: _____
Last **First** **Middle Initial** **Maiden Name**

Local Mailing Address: _____
Street# / Apt# **City** **State** **Zip**

Daytime Phone: ( ) **Alternate Phone: ( )**

Social Security # **Date of Birth: mm/dd/yyyy**

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____

Phone: _____

Mobile: _____

Address: _____

Place Patient Label Here

LAKE MARY SURGERY CENTER – Pre-Anesthesia Assessment

The amount of medication given to you during your procedure is adjusted according to your height and weight.
(La cantidad de medicacion dada a usted durante su procedimiento es ajustada segun su altura y peso).

Current: Height? *Altura?* _____ **Weight?** *Peso?* _____ **Age?** *Edad?* _____

Have you had surgery before? Yes ☐ **No** ☐ **If so, when and what kind of surgery?**
Ha teniedo usted cirugia antes? Que clase? _____

Have you or any members of your family had problems, INCLUDING FEVER, with prior anesthetics?
Usted o algun miembro de la familia a tenido problemas despues de cirujia,incluyendo fiebre con anestesicos previos?
Yes ☐ No ☐ if yes, explain:
Explicar? _____

Have you had any drug reactions or drug allergies? Yes ☐ **No** ☐
Ha teniedo usted alguna alergia/reaccion a algun medicamento?
If yes, please list the drug and describe the reaction _____
Describa la medicina y la reaccion
Circle if you have any of the following allergies: Circule si usted tiene alguna alergia a: **Iodine/Betadine** *(yodo / betadine)* **Seafood / Shellfish** *(mariscos/marisco)* **Morphine / Demerol** *(morfina / demorol)* **Sulfur / *Eggs*** *(azufre / huevos)*

Do you have or have you had any of the following? *Tiene usted o ha teniedo usted alguno de los siquientes?*	Yes	No	If Yes, give additional information
A. Thyroid or goiter problems *(Problemas de la Tiroide o bocio)*			
B. Diabetes or hypoglycemia *(Diabetis o hipoglucemia)*			
C. Epilepsy or seizures *(Epilepsia o convulciones)*			
D. High blood pressure or stroke *(Precion altao ataque de corazon)*			
E. Heart disease or mitral valve prolapse *(Enfermedad del Corazon o prolapso de la valvula mitral)*			
F. Chest pain or angina *(Dolor de pecho o angina)*			
G. Lung disease or emphysema *(Enfermedad de pulmones o efisema)*			
H. Chronic cough, asthma, or shortness of breath *(Tos cronica, asma o falta de oxigeno)*			
I. Hepatitis, cirrhosis, or jaundice *(Hepatitis, cirrosis o ictericia)*			
J. Kidney disease *(Enfermedad de los Riñones)*			
K. Ulcers or hiatal hernia *(Ulceras o hernia hiatal)*			
L. Anemia or sickle cell disease *(Anemia o enfermedad de ciclemia)*			
M. Recent weight loss *(Perdida de peso?)*			

Are you now or have you ever been in a drug recovery program? Yes ☐ **No**
Usted ah sido recluido en un programa de reabilitacion por drogas?

Do you drink more than 2 alcoholic beverages daily? Yes ☐ **No** ☐ **If so, how many?**
Usted consume bebidas alcholicas mas de 2 veces al dia?

PLACE PATIENT ID LABEL HERE

Do you smoke? Yes ☐ No ☐ **If yes, _____ Packs per day for _____ years.**

Usted fuma? *Cuantos paquetes al dia por cuantos años?*

Pre-Anesthesia Assessment Page 2 of 2

	Yes	No	Additional Information
Have you had broken facial bones? A tenido usted huesos fracturados en la cara?			
Have you had back, jaw, or nose surgery? A tenido usted cirujia en la espalda, mandibula o nariz?			
Do you use eye drops or wear contact lens? Usted usa gotas para los ojos o lentes de contacto?			
Do you have loose teeth, caps, crowns, or dentures? Usted tiene algun diente suelto, dentaduras, coronas o espigas?			
Have you had an abnormal chest film or EKG? A tenido usted un electrocardiograma abnormal?			
Do you have back trouble? Usted tiene problemas en la espalda?			
Are you pregnant? _____ Esta usted embarazada? **If not, when was your last period?** Cuando fue su ultima menstruacion?			
Have you had blood transfusion? A tenido usted transfusion de sangre?			
Do you take blood-thining medications? A tomado usted medicaciones para aflojar la sangre?			

Have you ever been diagnosed or told you are positive for HIV (virus that causes AIDS)? Yes No
Usted a sido diagnosticado con SIDA o con el virus que cause el SIDA?

Do you have any other illness or medical condition not mentioned above (e.g. cancer, neurological, etc?) Yes No
Usted a sido diagnosticado con otra enfermedad que no a sido mencionada arriba? (Cancer, neurologico, ect?)

Do you presently take any medications? If so, list the medication you take and the amount and frequency:
Usted toma algun medicamento ? Si toma por favor anote el nombre, dosis, cantidad y cada cuanto?

_____

_____

_____

Do you take vitamins, herbal medications, or herbal drinks? If so please list:
Usted toma vitaminas, medicamentos naturales o bebidas naturales?

_____

Patient's or guardian's signature
Firma del paciente o responsible del paciente **Date**

Anesthesia Care Provider's (ACP) ASA : See Anesthesia Record

Respiratory: Bi-laterally clear Yes ☐ NO ☐ Other ☐

Cardiac: Regular Rate & Rhythm, No Significant Murmur Yes ☐ NO ☐ Other ☐

_____

_____

_____

Anesthesia Care Provider's Signature: _____ **Date:** _____

Lake Mary Surgery Center

AGREEMENT TO MEDICAL AND SURGICAL PROCEDURES: The undersigned agrees to the procedures which may be performed including but not limited to laboratory, radiology, medical or surgical treatment or procedures, anesthesia or outpatient services rendered to the patient under the general and special instructions of the patient=s physician.

INFORMATION FOR CONSENT: I understand that my physician has determined that the procedure(s) to be performed may be beneficial to me. All surgical operations, diagnostic and therapeutic procedures involve risks of unsuccessful outcomes, complications, injury or even death from both known and unforeseen causes. No warranties or guarantee has been made as to result of care. As a patient I understand I have the right to receive as much information as I need in order to give informed consent or to refuse the recommended course of treatment. Except in emergencies, my physician should describe in language I can understand, the nature of the ailment and the nature of the proposed procedure, the material risks or dangers involved, the alternate courses of treatment or non-treatment, including the respective risk of unfortunate consequences associated with the procedure, and the relative probability of success of the procedure. If I have questions, I understand I am expected to consult with my physician(s) prior to giving my consent to any procedure. I understand I have the right to consent or refuse any proposed procedure prior to its performance.

ACKNOWLEDGMENT OF INFORMED CONSENT: I certify that I fully understand the necessity, nature and risks of the procedure(s) for which I have given consent to my physician, as well as the treatment alternatives; the explanations to any questions I may have had are understood by me; all my questions have been answered; and my consent was given freely, voluntarily and without reservation. I understand that I have the right to refuse medical and surgical procedures and treatment.

ADULT COMPANION: I understand that I am required to have a competent companion accompany me after my procedure and that I will be released to that person=s custody and must rely on him/her for my return home and supervision as instructed.

OBSERVER AND/OR FILMING: I agree an observer or clinical or technical representative(s) may be present for my procedure at my physician=s direction. I understand a video tape or a film may be made of all or part of the procedure for research, training, or medical records.

LABORATORY TESTING FOR EXPOSURE TO INFECTIONS: In the event of blood or fluid exposure to medical personnel involved in my care, I authorize and consent to the drawing of my blood for the purpose of conducting HIV or Hepatitis testing. In the event that such exposure does occur, I will be notified and the exposure will be recorded in my medical record. I understand that the test is not 100% reliable and may, in some cases, indicate a false positive or a false negative. A second test may be necessary to confirm results. If there is a positive test result, health care practitioners who were directly responsible for my care will be informed of this result so that proper treatment can occur. My identification and results of the test are confidential and protected against further disclosure to the extent provided by law.

AUTHORIZATION: Having read and fully understood the above, and having received and fully understood information from my physician, I hereby authorize my physician and any of his/her associates or assistants to perform the above-named procedure(s) and to provide additional services as may be deemed medically reasonable and necessary, including, but not limited to:

1) Those resulting from conditions or discoveries, which in the opinion of the professional make a change or extension advisable.
2) Administration and maintenance of anesthesia considered necessary or advisable by the professional responsible for such services.
3) The implant of medical devices.
4) Services involving pathology and radiology.
5) Related follow-up care.

I hereby acknowledge the above statements.

Patient _____ Date _____ Witness _____ Date _____

(In the event the patient is a minor, unconscious, or is otherwise not competent to acknowledge an understanding due to physical or mental condition, complete the following.)

If patient's personal representative, state relationship and authority:

Patient's Representative _____ Date _____ Witness _____ Date _____

PLACE PATIENT I.D. LABEL HERE

SURGERY CENTER ADMISSION

LEGAL RELATIONSHIP BETWEEN SURGERY CENTER AND PHYSICIANS: I understand that all physicians furnishing services to the patient, including the patient's physician, and any specialist such as an anesthesia provider, radiologist, or pathologist are independent contractors with the patient and are not employees or agents of the surgery center. The patient is under the care and supervision of his/her physician and it is the responsibility of the surgery center and its staff to carry out instructions of the physician. It is the responsibility of the patient's physician to obtain the patient's informed consent, to medical or surgical treatment or procedures. Any questions concerning the nature or results of any examination or treatment should be directed to the patient's physician and not to the surgery center employees.

OTHER PROFESSIONAL SERVICES: I understand that my physician may have a professional radiology service review radiological images. My physician may also send specimens to a professional pathology laboratory for a pathological diagnosis. Radiology and pathology services are billed separately by those individual physicians and laboratories.

PERSONAL VALUABLES: It is agreed and understood that the surgery center shall not be responsible for any personal property brought by patient to the surgery center, including but not limited to money, jewelry, documents, or any other articles.

OWNERSHIP OF SURGERY CENTER: I have been informed there are physicians who have ownership in this surgery center. I understand that I am free to choose another facility in which to receive services.

ADVANCE DIRECTIVE/LIVING WILL: I understand that if an emergency medical condition should occur I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advance directive or living will, the surgery center will still transfer me to a hospital which will make decisions about following any advance directives or living will. If I should be transferred to a hospital, I consent to the hospital to release copies of my medical records to the surgery center to review the episode of care.

I have the following:	Copy given to Surgery Center
☐ Living will	☐
☐ Health care surrogate, proxy, or durable power of attorney	☐
☐ Power of Attorney	☐

PATIENT PRIVACY, RIGHTS AND RESPONSIBILITIES: I have been offered a copy of the Privacy Notice. I received a copy of the patient rights and responsibilities statement. I know to whom I can express suggestions or complaints.

FINANCIAL AGREEMENT: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the Center's charges (including but not limited to insurance companies, health care service plans, or worker's compensation carriers).Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay the Center for all such services, at the Center's regular rates and terms should my insurance company deny payment. I shall also be responsible for any deductibles or co-payments owed at the time of services. I am responsible for payment within 60 days of the date of the service provided unless there is a contract the surgery center has signed with my insurer that states otherwise. Should this account be referred for collection to any attorney or collection agency, I shall pay all attorneys' fees and collection expenses in connection therewith, if the patient's account is delinquent. I shall be responsible for paying the Center interest on the full outstanding balance at the maximum rate allowed by law. I hereby certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act or by any other payer is correct. I assign to the Surgery Center all benefits due me under the terms of said policies and programs but not to exceed the Center's regular charges for similar services. **I authorize payment of medical benefits to the surgery center for the services provided.**

I hereby acknowledge the above statements.

I also acknowledge that I have received the following items prior to the date of the procedure.
- ☐ Patient Rights and Responsibilities
- ☐ The surgery center's policy about advance directives
- ☐ Physician ownership information

Patient Date Time

Witness Date Time

(In the event the patient is a minor, unconscious, or is otherwise not competent to acknowledge an understanding due to physical or mental condition, complete the following.)

If patient's personal representative, state relationship and authority:

Patient's Representative Date Time

Witness Date Time

Place Patient ID Label Here

Lake Mary Surgery Center

460 St. Charles Court

Lake Mary, FL 32746

The Lake Mary Surgery Center is committed to providing you with quality customer service. Our commitment to service means that we strive to provide quality service in a timely fashion, and to meet the overall satisfaction of all of our patients.

We need the same level of commitment from our patients, with regards to keeping scheduled appointments. If you are unable to keep your scheduled appointment, you must notify the surgery center 24 hours in advance. Appointments that are not cancelled 24 hours in advance, will be considered to be a no show, and assessed a $50.00 fee after two (2) no show appointments.

To cancel or re-shcedule an appointment, please call (407) 585-0263.

_____ _____

Customer Signature Date

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

The staff of this health care facility recognizes you have rights while a patient receiving medical care. In return, there are responsibilities for certain behavior on your part as the patient. These rights and responsibilities include:

A patient has the *right* to

< be treated with courtesy and respect, with appreciation of his individual dignity, and with protection of his need for privacy and without being subjected to discrimination.
< a prompt and reasonable response to questions and requests.
< know who is providing medical services and who is responsible for his care.
< know what patient support services are available, including whether an interpreter is available if he does not speak English.
< know what rules and regulations apply to his conduct and to be free from abuse or harassment.
< be given by his health care provider information concerning diagnosis, a planned course of treatment, alternatives, risks, and prognosis.
< refuse treatment, except as otherwise provided by law.
< be given, upon request, full information and necessary counseling on the availability of known financial resources for his care.
< know, upon request and in advance of treatment, whether the health care provider or health care 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 charges explained.
< impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical disability, or source of payment.
< treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
< know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.
< express concerns regarding any violation of patient rights.
< have the right to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.

A patient is *responsible* for

< providing to his health care provider, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, including over-the-counter products and dietary supplements and any allergies or sensitivities or any other matters relating to his health.
< following the treatment plan recommended by his health care provider.
< accept personal financial responsibility for any charges not covered by his/her insurance.
< be respectful of all the health care providers and staff, as well as other patients.
< provide a responsible adult to transport him/her from the facility and remain with him/her for 24 hours, if required by his provider.
< inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

COMPLAINTS

If you have a question or concern about your rights or responsibilities, please let us know. We want to assure that we provide you with excellent service, including answering your questions and responding to your concerns.

You may also choose to contact the licensing agency of the state,
Agency for Health Care Administration at 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 www.Medicare.gov

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PRIVACY NOTICE

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.

This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes permitted or required by law. We must follow the privacy practices described in this Notice while it is in effect. We reserve the right to change the terms of this Notice and to make the new Notice effective for all future protected health information we maintain. We will post the most current Notice and make the new Notice available to anyone. You may request a copy of current Notice at any time. This Privacy Notice also describes your rights to access and control your Aprotected health information@ which is health information that is created or received by your health care provider.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We will use and disclose health information to provide treatment, obtain payment, and conduct health care operations.

1. **Treatment:** To provide and coordinate your health care. For example, we may disclose protected health information to physicians or other health care professionals who may be treating you or consulting with us. Examples include your physicians, anesthesia provider, or pharmacist.
2. **Payment:** To obtain payment for the services. This may include contact with your insurance company to get the bill paid and to determine benefits of your health plan. We may also disclose information to another provider involved in your care so the provider can get paid. For example, we may give information to anesthesia providers so they can contact your insurer about payment for their services.
3. **Operations:** To perform our own health care activities such as quality assessment and improvement, licensing or credentialing, and general business administration.
4. **Other Uses and Disclosures:** To remind you of appointments or to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, or to notify family or others involved in your care concerning your location or condition. You may object to these disclosures. If you do not or cannot object, we will use our professional judgment to make reasonable assumptions about to whom we can make disclosures.
5. **Other Uses and Disclosures Permitted:** to comply with laws and regulations.
   - A. **When Legally Required** by any federal, state or local law.
   - B. **When There Are Risks to Public Health** such as:
     - To prevent, control, or report disease, injury or disability as required or permitted by law.
     - To report vital events such as birth or death as required by law.
     - To conduct public health surveillance, investigations and interventions as required by law.
     - To collect or report adverse events and product defects, track Food and Drug Administration (FDA) regulated products, enable product recalls, repairs or replacements and review.
     - To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
     - To report to an employer information about an individual who is a member of the workforce as legally permitted or required.
   - C. **To Report Suspected Abuse, Neglect Or Domestic Violence** as required by law.
   - D. **To Conduct Health Oversight Activities** such as audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensing or disciplinary actions; or other activities necessary for appropriate oversight as required or authorized by law.
   - E. **In Connection With Judicial And Administrative Proceedings** such as in the course of any judicial or administrative proceeding.
   - F. **For Law Enforcement Purposes.** Examples are:
     - As required by law for reporting of certain types of wounds or other physical injuries.
     - Upon court order, court-ordered warrant, subpoena, summons or similar process.
     - For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
     - Under certain limited circumstances, when you are the victim of a crime.
     - To law enforcement if there is concern that your health condition was the result of criminal conduct.
     - In an emergency to report a crime.
   - G. **For Organ Donation or to Coroners or Funeral Directors** such as for organ, eye or tissue donations; identification purposes; performing other duties authorized by law.

H. **For Research Purposes** when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.
I. **In the Event of a Serious Threat to Health or Safety** and consistent with applicable law and ethical standards of conduct, if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat. to your health or safety or to the health and safety of the public.
J. **For Specified Government Functions** relating to military and veterans activities, national security, protective services, medical suitability determinations, correctional institutions, and law enforcement situations.
K. **For Worker's Compensation** to comply with worker's compensation laws or similar programs.

PATIENT RIGHTS

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action based upon the authorization. At the end of this Privacy Notice is information about how to contact the Privacy Officer to request information, copies, express concerns, complain, or authorize additional uses and disclosure of your health information.

YOU HAVE THE RIGHT TO:

1. **See and copy your medical records** and other records used to make treatment and payment decisions about you. There are some limitations, based upon the federal law. You must submit a written request. We may charge you a fee for copying, mailing or incurring other costs in complying with your request. We may deny your request to see or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger life or safety of you or another person. You have the right to request a review of this decision.
2. **Request a restriction on uses and disclosures of your protected health information.** The facility is not required to agree to a restriction and we will notify you if we deny your request. If the facility does agree to the requested restriction, we will abide by this agreement unless use or disclose of the information becomes essential to provide emergency treatment.
3. **The right to request to receive confidential communications by alternative means or at an alternative location.** You have the right to request that we communicate with you in certain ways. We will not require you to provide an explanation for your request. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact.
4. **The right to request we amend your protected health information.** A request for an amendment must be in writing and it must explain why the information should be amended. Under certain circumstances, we may deny your request.
5. **The right to receive an accounting of disclosures.** You have the right to request an accounting of how we or our business associates disclosed your protected health information for purposes other than treatment, payment or health care operations. We are not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing. We are not required to provide an accounting for disclosures that occurred prior to April 14, 2003 or for periods of time in excess of six years. The first accounting you request during any 12-month period will be without charge. Additional accounting requests may be subject to a reasonable fee.
6. **The right to obtain a paper copy of this notice at any time.**

COMPLAINTS

You have the right to express complaints to the facility if you believe that your privacy rights have been violated. We encourage you to express any concerns you have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint. You may complain to the facility=s Privacy Officer in person, by phone, or in writing. You also have the right to express complaints to the Secretary of the United States Department of Health and Human Services.

CONTACT PERSON

TO MAKE REQUESTS, TO LEARN MORE, TO FILE A COMPLAINT, OR TO EXPRESS CONCERNS, PLEASE CONTACT THE PRIVACY OFFICER. YOU MAY MAKE CONTACT IN PERSON, BY PHONE, OR IN WRITING.

ATTENTION: PRIVACY OFFICER