PEDIATRIC SURGERY CENTERS

Dear Parents/Guardians,

Enclosed you will find the necessary documentation to be completed and returned to Pediatric Surgery Centers on the day of your child's scheduled surgery. Please read all of the documents carefully, and complete them to the best of your ability.

A nurse will contact you 1-2 days prior to your child's scheduled surgery. They will provide pre-operative instructions, as well as an estimated time of surgery.

Important:

- If your contact information has changed since you scheduled surgery, please call the center to update contact information
- If you are not biological parents, please bring all necessary legal documentation. Not having correct documentation may result in cancellation of surgery. If you have any questions regarding the documentation you have, please call the center.
- Photo ID is required of the person legally signing the consent for surgery. If the patient is 18 years old or older, he/she will need to provide their own photo ID.

On behalf of Pediatric Surgery Centers, I would like to thank you for choosing us as your healthcare provider.

If you have any questions or concerns, please do not hesitate to contact us. We will be happy to answer any questions that you may have.

Sincerely,

Teri Ulm, RN
Administrator
Pediatric Surgery Center-Brandon
Odessa

www.surgerycenterforkids.com

PEDIATRIC SURGERY CENTERS-PATIENT REGISTRATION

PATIENT INFORMATION

Last Name _____ First _____ MI _____

Date of Birth ___/___/_____ Age _____ Sex _____ SS# _____

Address _____ Apt/Unit# _____

City _____ St _____ Zip _____ Phone _____

Race: __African American-Black __American Indian __Asian-Pacific Islander

__Black Hispanic __Caucasian White __Native Alaskan __White Hispanic

Nationality: _____Hispanic/Latino _____Non-Hispanic/Latino _____ Unknown

Family Physician/Pediatrician _____ Phone # _____

LEGAL PARENT/GUARDIAN INFORMATION

Mother/Legal Guardian 1 Name _____ SS# _____ DOB _____

Address _____ Apt/Unit# _____

City _____ St _____ Zip _____ Phone _____

Driver's License # _____ Relationship to patient _____

Employer Name _____ Phone # _____

Father/Legal Guardian 2 Name _____ SS# _____ DOB _____

Address _____ Suite# _____

City _____ St _____ Zip _____ Phone _____

Driver's License # _____ Relationship to patient _____

Employer Name _____ Phone # _____

Child Lives With _____

INSURANCE INFORMATION

Insurance Company _____

Main Policy Holder _____ Relationship to Patient _____

Main Policy Holder's Date of Birth ___/___/___ Social Security Number _____

Policy/Id # _____ Group Name/Number _____

Secondary Insurance (If Applicable)

Insurance Company _____

Main Policy Holder _____ Relationship to Patient _____

Main Policy Holder's Date of Birth ___/___/___ Social Security Number _____

Policy/Id # _____ Group Name/Number _____

STATEMENT OF TRUTHFULNESS. I state that any and all of the information provided is true and correct. Further, I understand that this form may be shared between Pediatric Surgery Centers LLC and Physician practices.

Signature _____ Print Name _____ Date _____

IMPORTANT INSTRUCTIONS

PRE-OPERATIVE GUIDELINES

The following are guidelines that **must** be followed prior to your child's surgery. Not following dietary instructions may result in cancellation of your child's scheduled surgery

No food, milk, milk products or formula after midnight the night prior to surgery.

ONLY clear liquids up to 3 hours prior to estimated surgery time.

Clear liquids consist of only:

Water
Gatorade-any color
Pedialyte-any flavor
Popsicles-no fruit pieces or fudgesicles
Italian Ice-any flavor
Icee or Slurpee

Nursing infants may breast feed up until 6 hours prior to surgery, and then may continue with clear liquids up to 3 hours prior to estimated surgery time.

A nurse will contact you 1-2 days prior to surgery with arrival time, estimated surgery time and specific times for dietary restrictions

Please note: Arrival time is not scheduled surgical time

PEDIATRIC SURGERY CENTERS

SUMMARY OF THE PATIENT'S RIGHTS AND RESPONSIBILITIES – ENGLISH VERSION

PATIENT, OTHER PATIENTS, OR STAFF OF THE FACILITY OR OFFICE OR CANNOT BE REASONABLY ACCOMMODATED BY THE FACILITY OR PROVIDER.

PATIENT RESPONSIBILITIES:

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible to inform his/her provider about any living will, medical power of attorney, or other advance directive that could affect his/her care.

A patient is responsible to provide a responsible adult to transport him/her from the facility and remain with him/her for twenty-four (24) hours, if required by his/her provider, as appropriate.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible to accept personal financial responsibility for any charges not covered by his/her insurance.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

A patient is responsible to be respectful of the rights of other patients and health care personnel and to be respectful of the property of other persons and of the facility.

Filing Complaints - Medicare Ombudsman
http://www.medicare.gov/claims-and-appeals/medicare-rights/medicare-rights-overview.html
or Call 1-800 MEDICARE
By mail: 7500 Security Boulevard
Baltimore, Maryland 21244-1850

If you have a complaint against a health care facility call the Consumer Assistance Unit at: 1-888-419-3456 (Press # 1) or write to the address listed below:

AGENCY FOR HEALTH CARE ADMINISTRATION
2727 MAHAN DRIVE
TALLAHASSEE, FL 32308

OR

AGENCY FOR HEALTH CARE ADMINISTRATION
CONSUMER ASSISTANCE UNIT
DOH/MQA-CSU
4052 BALD CYPRESS WAY, BIN C-75
TALLAHASSEE, FL 32399-3275

If you have a complaint against a health care professional and want to receive a complaint form, call the Consumer Services Unit at 1-850-245-4339 or write to the address below:

DIVISION OF MEDICAL QUALITY ASSURANCE
CONSUMER SERVICES UNIT
4052 BALD CYPRESS WAY, BIN C-75
TALLAHASSEE, FL 32399-3275
www.FLHealthsource.com

If you have a complaint against a hospital or ambulatory surgical center, you may contact Accreditation Association for Ambulatory Health Care (AAAHC) at:
1-847-853-6060 or write to the address listed below:

AAAHC INSTITUTE FOR QUALITY IMPROVEMENT
5250 OLD ORCHARD ROAD, SUITE 250
SKOKIE, ILLINOIS 60077

If you have a complaint against a laboratory's operation you may contact the Centers for Medicare and Medicaid Services (CMS) Central Office, Division of Laboratory Services (CLIA), in Baltimore, Maryland at (410) 786-3531 locally or at (877) 267-2323 (toll free) extension 63531.
If you have a civil rights complaint against a health care provider, you may submit a written complaint to the US Department of Health and Human Services at:

CENTRALIZED CASE MANAGEMENT OPERATIONS
US DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 INDEPENDENCE AVENUE SW
ROOM 509F HHH BUILDING
WASHINGTON, DC 20201
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Pediatric Surgery Centers-Brandon, LLC participates with most health insurance plans. If a patient is not a member of any of the plans that we are contracted with, we will be more than to discuss this with them and even consider joining their plan.

The cost of a visit depends on the services performed by the physician. Unless other arrangements have been made, payment is expected at time of service. As a service to our patients, we will file on their health insurance(s), we do ask that payment of any deductible, co-insurance, or co-pays be made at the time the service is rendered.

Due to legalities with contracted plans that our office participates with, we are unable to accept only the amount the patient's insurance company pays. When participating with a contracted plan, we are legally required to bill patients for any remaining balance. This includes deductibles, co-insurance, or co-pays. If a patient has no insurance, or does not provide us with verification (i.e. Insurance Cards) of insurance, they are considered to be a self-pay patient. Patients without insurance will be expected to pay for all charges in full prior to surgery.

We feel our fees are appropriate and fair. However, if you have any questions regarding them or a statement you have received, please give us a call.

We Accept: Cash, Check, Visa, Mastercard, Discover Card, and Debit Card

Collection Policy

As with any business, we adhere to a collection policy that ensures that we have the financial means to maintain this healthcare facility for our patients. Therefore, if a patient account becomes past due, we will take action to recover the amount due. After 90 days have passed from the balance becoming the patient's responsibility the account will be sent to a collections agency.

Not all insurance will pay 100% of our charges. The patient (and/or spouse/guarantor) is responsible to pay all sums unpaid by insurance. If it becomes necessary to collect any sum through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not. All past due balances will accrue interest at the rate of 18% per annum. The patient authorizes the release of any information acquired in the course of treatment as necessary to file insurance claims.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance company benefits be paid directly to Pediatric Surgery Centers-Brandon or Odessa.

I authorize Pediatric Surgery Centers-Brandon or Odessa to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date:_____

Signature of Insured or Authorized Person_____

Print Name_____

Pediatric Surgery Centers
Notice of Privacy

This notice describes how medical information about your child may be used and disclosed and how you can get access to this information. **Please read carefully.** The following is the privacy policy of Pediatric Surgery Centers-LLC(PSC) as described in the Health Insurance Portability Accountability Act of 1996 and regulations promulgated there, commonly known as HIPAA. HIPAA requires PSC, by law, to maintain the privacy policies with respect to your child's personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Child's Health Information

We collect your child's personal health information from your through treatment, payment and related healthcare operations, the application process, and/or healthcare providers or health plans, or through other means as applicable. Your child's personal health information that is protected by law broadly includes any information, oral, written, or recorded, that is created or received by certain healthcare entities, including healthcare providers, such as physicians and hospitals, as well as health insurance companies or plans. The law specifically protects health information that contains data such as your child's name, address, social security numbers and others that could be used to identify your child as the individual patient who us associated with that health information.

Disclosure Of Your Child's Personal Health Information

Generally, we may not use or disclose your child's personal health information without permission. Further, once your permission has been obtained, we must use or disclose your child's personal health information in accordance with specific terms of that permission. The following are circumstances under which we are permitted by law to use or disclose your child's personal health information.

Without Consent

Without your consent, we may use or disclose your child's personal health information in order to provide him/her with the services and treatment he/she requires or requests or to collect payment for those services and to conduct other related health care operations otherwise permitted by law. **Examples of treatment activities include:** (a) the provision, coordination, or management of healthcare related services by healthcare providers; (b) consultation between healthcare providers relating to patient; (c) the referral of a patient for healthcare from one healthcare provider to another. **Examples of payment activities include:** (a) billing and collection activities and related data processing; (b) actions by health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums and reimbursement. **Examples of healthcare operations include:** (a) development of clinical guidelines; (b) contacting patient's parents/legal guardians with information about treatment alternatives or communications with case management or care coordination; and (c) medical review, legal services and auditing functions.

As Required By Law

We may use or disclose your child's personal health information to the extent that such use or disclosure is required by law and the use of disclosure complies with and is limited to the relevant requirements of such law. **Examples include:** (a) to notify or assist in notifying the parent, legal guardian or family member responsible for your child's care about his/her medical condition or in the event of an emergency or death: (b) to public health authorities for purposes related to; preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting Food and Drug administration problems with products and reactions to medications, reporting disease or infection exposure; (c) to judicial and administrative proceedings in the course of any legal proceeding; (d) to law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes; (e) to coroners or medical examiners; (f) to researchers conducting research that has been approved by an Institutional Review Board; (g) to avert a serious threat to health or safety; and (h) to provide you with appointment reminders for your child, or information about treatment alternatives or other health related benefits and services that may be of interest to you. **Miscellaneous Activities:** In the event that PSC is sold or merged with another organization, your child's health information/record will become property of the new owner.

Your Rights with Respect To Your Child's personal Health Information

Under HIPAA, you have certain rights with respect to your child's personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

You have the right :(a) to request restrictions on certain uses and disclosures of your child's health information(Please be advised that PSC is not required to agree to the restriction that you have requested); (b)to have your child's health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request;(c) to have the right of access in order to inspect and obtain a copy of your child's health information contained your child's designated record, except for psychotherapy notes, information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action proceeding or action, and health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We will require written requests.

You have the right to: (a) request PSC amends your child's protected health information. Please be advised, that PSC is not required to agree to amend your child's protected health information. If your request to amend your child's health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with denial; (b) to receive accounting of disclosures of your child's protected health information made by PSC; and (c) to a paper copy of this Notice of Privacy Policy at any time upon request.

Amendments

We reserve the right to amend this policy at any time in the future, and will make new provisions effective for all information that it maintains. Until such amendment is made, PSC is required by law to comply with this notice. PSC is required by law to maintain the privacy of your child's health information and to provide you with notice of its legal duties and privacy policies with respect to your child's health information. If you have any questions or complaints about any part of this notice or require more information, please contact Administrator at Pediatric Surgery Center. If he/she unavailable, you may make an appointment for a personal meeting or telephone conference within 2 working days.

Complaints about your privacy rights or how PSC handled your child's health information should be directed to Administrator at 813-343-5690. If not satisfied, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Ave, S.W. Room 509F HHH Building. Washington, DC 20201.

Pediatric Surgery Centers
Mission Statement

The mission of the Pediatric Surgery Centers is to create an optimal environment for the physical, social, and psychological well-being of the pediatric surgical patient and family. Our mission requires a commitment to quality, safety and education from the facility's medical staff and employees. Our mission is accomplished by providing personalized attention to each patient and family by maintaining a well-trained, professional and caring staff. Pediatric Surgery Centers is responsive to the needs of the community by lowering the cost of providing quality healthcare, and to generate medically effective and cost-effective solutions for patients, physicians, payers and employees.

Patients Rights and Responsibilities
In recognition of our responsibility in rendering patient care, these rights and responsibilities are affirmed in the policies and procedures
The patient has the right

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

Patients Rights and Responsibilities
In recognition of our responsibility in rendering patient care, these rights and responsibilities are affirmed in the policies and procedures of
A patient is responsible

For providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
For reporting unexpected changes in his or her condition to the health care provider.
For reporting to the healthcare provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
For following the treatment plan recommended by the health care provider.
For keeping appointments and when he or she is unable to do so for any reason, for notifying the health care facility.
For his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
For following facility rules and regulations affecting patient care and conduct..
For consideration and respect of the facility staff and property.

Filing Complaints

If you have a complaint against an ambulatory surgical center, call the Consumer Assistance Unit at 1-888-419-3456 (press 1)

Or write to the address listed below:
Agency for Healthcare Administration
Consumer Assistance Unit
2727 Mahan Drive/Bldg 1
Tallahassee, Fl 32306

If you have a complaint against a health care professional and want to receive a complaint form, call the Consumer Assistance Unit at 1-888-419-3456 (press 2)
Or write to the address listed below:
Agency for Health Care Administration
Consumer Services Unit
PO Box 14000
Tallahassee, Fl 32317-4000

Pediatric Surgery Centers-Brandon, LLC participates with most health insurance plans. If a patient is not a member of any of the plans that we are contracted with, we will be more than to discuss this with them and even consider joining their plan.

The cost of a visit depends on the services performed by the physician. Unless other arrangements have been made, payment is expected at time of service. As a service to our patients, we will file on their health insurance(s), we do ask that payment of any deductible, co-insurance, or co-pays be made at the time the service is rendered.

Due to legalities with contracted plans that our office participates with, we are unable to accept only the amount the patient's insurance company pays. When participating with a contracted plan, we are legally required to bill patients for any remaining balance. This includes deductibles, co-insurance, or co-pays. If a patient has no insurance, or does not provide us with verification (i.e. Insurance Cards) of insurance, they are considered to be a self-pay patient. Patients without insurance will be expected to pay for all charges in full prior to surgery.

We feel our fees are appropriate and fair. However, if you have any questions regarding them or a statement you have received, please give us a call.

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I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance company benefits be paid directly to Pediatric Surgery Centers-Brandon or Odessa.

I authorize Pediatric Surgery Centers-Brandon or Odessa to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date:_____

Signature of Insured or Authorized Person_____

Print Name_____

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Your Child's Health Information

We collect your child's personal health information from your through treatment, payment and related healthcare operations, the application process, and/or healthcare providers or health plans, or through other means as applicable. Your child's personal health information that is protected by law broadly includes any information, oral, written, or recorded, that is created or received by certain healthcare entities, including healthcare providers, such as physicians and hospitals, as well as health insurance companies or plans. The law specifically protects health information that contains data such as your child's name, address, social security numbers and others that could be used to identify your child as the individual patient who us associated with that health information.

Disclosure Of Your Child's Personal Health Information

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You have the right to: (a) request PSC amends your child's protected health information. Please be advised, that PSC is not required to agree to amend your child's protected health information. If your request to amend your child's health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with denial; (b) to receive accounting of disclosures of your child's protected health information made by PSC; and (c) to a paper copy of this Notice of Privacy Policy at any time upon request.

Amendments

We reserve the right to amend this policy at any time in the future, and will make new provisions effective for all information that it maintains. Until such amendment is made, PSC is required by law to comply with this notice. PSC is required by law to maintain the privacy of your child's health information and to provide you with notice of its legal duties and privacy policies with respect to your child's health information. If you have any questions or complaints about any part of this notice or require more information, please contact Administrator at Pediatric Surgery Center. If he/she unavailable, you may make an appointment for a personal meeting or telephone conference within 2 working days.

Complaints about your privacy rights or how PSC handled your child's health information should be directed to Administrator at 813-343-5690. If not satisfied, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Ave, S.W. Room 509F HHH Building. Washington, DC 20201.

Pediatric Surgery Centers
Brandon Odessa

Patient Disclosure Statement

Pediatric Surgery Centers is a Limited Liability Corporation (LLC), which is owned by practicing specialists, one of which may be your physician. These parties have become owners as a result of their commitment to the highest quality healthcare and superior customer service. Pediatric Surgery Centers may have a financial relationship with your physician, as indicated. You have a right to choose an alternative source of service. Please contact your physician to obtain a list of sites he/she may have privileges to practice. A schedule of typical fees for services by facility is available at your request.
Initials:_____

Acknowledgement Of Receipt of Patients Rights and Responsibilities

I acknowledge that I have received and understand Patients Rights and Responsibilities.
Initials:_____

Acknowledgement Of Receipt of Privacy Notice

I acknowledge that I received Notice of Privacy Policy and understand my rights.
Initials:_____

Acknowledgement Of Receipt of Advance Directives *(Patient 18 and Older Only)*

I acknowledge that it is the policy of Pediatric Surgery Centers to not accept Advance Directives. Information regarding Advance Directives will be given to me by request.

Patient Name:_____ Date of Birth:_____

Signature Pt:_____ Date:_____

Clinical Research Study Questionnaire

1. Are you participating in a research study? No / Unknown / Yes
2. If yes, please complete the required information below:

Study Name: _____
Name of physician conducting study: _____
Physician contact info:
Address: _____
Phone Number: _____

Patient Name: _____ **Date of Birth:** _____

Print Parent/Guardian Name:_____

Signature Parent/Guardian:_____ **Date:**_____