FAMILY CARETAKER STATUS

*

Please list responsible adult whom you will be discharged to:

_____ _____

Name *Relationship*

Contact Phone Number(s) of Family/Caretaker on date of surgery:

_____ Cell/Home/Work (circle one)

Permission for caretaker to discuss medical information with physician**:** _____ ***Yes*** _____ ***No***

Please check the appropriate box:

_____ Responsible person will remain in the Center.

_____ Responsible person plans to leave the Center for a brief time and will return by: _____ (am) (pm).

_____ Responsible person is leaving and would like to be called when patient comes out of surgery at the number listed above.

*****Note:*** *Do not go more than 15 minutes away from center.*

TRANSPORTATION RELEASE: I understand that the anesthetic administered to me may affect my ability to drive a car or otherwise travel alone to my home following my procedure. I have arranged for transportation with a responsible adult to my home and will also be under the supervision of a responsible adult for 24 hours following my procedure.

I acknowledge procedure will be discussed with caretaker if relevant to discharge and post-operative care instructions.

_____ _____ _____

Patient or Patient Representative **Date** **Relationship to Patient**

DEMOGRAPHIC INFORMATION

Patient's Name: _____**DOB:** _____

SSN: _____ **Ph:** _____ **Marital Status:** ☐Single ☐Married ☐Widowed

Address: _____

Gender:_____ **Email:** _____

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ White ☐ Decline

Ethnicity: ☐ Hispanic or Latino/Spanish American ☐ Not Hispanic or Latino ☐ Decline

PATIENT'S PREFERENCES REGARDING THEIR PHI & HIPAA ACKNOWLEDGMENT

We may contact you with appointment, financial, billing and PHI information via telephone, email, text message and mailing address provided at registration unless otherwise specified here:_____

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 Destin 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. If an email address has been provided, Destin Surgery Center or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation. I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. You may opt out of text messages at any time. If you consent to receiving text messages you also agree to promptly update us when your phone number changes. You are not required to authorize the use of text messaging and a decision not to authorize text messaging will not affect your health care in any way.*

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your protected health care information? You should review the *Notice of Privacy Practices* (NPP) for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form. By signing this form, I authorize Destin Surgery Center to use and/or disclose certain PHI about me to the contact(s) listed below:

		Name:	**Telephone**
☐	Spouse	_____	_____
☐	Caretaker	_____	_____
☐	Child	_____	_____
☐	Other	_____	_____

I acknowledge I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information (PHI) and I have been given the opportunity to request alternative means of communication of my PHI. I further acknowledge I have reviewed the content of the *Patient Rights & Responsibilities* and *Notice of Privacy Practices* and have had the opportunity to receive a copy if requested.

_____ _____ _____

Patient or Patient Representative **Date** **Relationship to Patient**

PATIENT POLICIES

RELEASE OF INFORMATION:
Destin Surgery Center and each attending or treating practitioner, including, if applicable, PATHOLOGY, ANESTHESIA, and/or RADIOLOGIST, are hereby authorized and directed to disclose my protected health information (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third party payers including, but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers, manufacturers required by FDA to track medical devices, or my employer as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement. This includes appropriate release of and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST:
I certify that the information given by me in applying for payment under Title XVII or 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.

NOTICE OF PRIVACY PRACTICES (NPP):
NPP is provided to all patients. The NPP 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 NPP and is the patient, or the patient's personal representative.

PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge I have received a copy of the Patient Rights and Responsibilities, which includes information regarding where and how I can file a grievance or complaint and how I can obtain a written estimate of procedure cost.

DISCLOSURE OF OWNERSHIP: Destin Surgery Center provides services to patients admitted by practitioners who are medical staff members approved by the Governing Board. The physician who refers you to our Surgery Center may have an ownership interest in this facility. I acknowledge I am free to choose another facility in which to receive services. I acknowledge I have reviewed and been offered a copy of this information as listed in the Patient Rights and Responsibilities document.

ADVANCE DIRECTIVES POLICY:
I understand that the majority of procedures performed at Destin Surgery Center are considered to be of minimal risk. I understand the policy of Destin Surgery Center (regardless of the contents of any advance directive or instructions from a health care surrogate attorney in fact), that if an adverse event occurs during my treatment, the medical team will initiate resuscitative or stabilizing measures and transfer me to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with my 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, the undersigned chooses to proceed with his/her procedure at Destin Surgery Center.**

Do you have an advanced directive? **CHOOSE ONE.**
_____YES I brought my Advanced Directive with me to place in my chart as part of my medical record.
_____YES I have an Advanced Directive but I did not bring it with me.
_____NO I do not have an Advanced Directive.

_____ _____
Patient or Patient Representative **Date**

COSMETIC FINANCIAL AGREEMENT FOR ELECTIVE SELF-PAY PROCEDURES

Professional fees (i.e., anesthesia, physician fees, lab fees) are excluded from the Cosmetic Self Pay Facility Rate unless otherwise indicated. You may receive a separate bill for these professional services.

I understand the Cosmetic Self Pay Rate quoted for my procedure **is an estimate** and based on the operative time scheduled by my physician and per the facility's this estimated facility fee is required to be paid in full at the time of service. I understand if additional operative time other than what was scheduled and those generally included in this agreement are required by my physician, **I will be billed and responsible for payment of those additional facility fees in full.**

I understand and agree to accept full financial responsibility for the surgery center costs associated with my cosmetic procedure. I agree to pay any unpaid balances on my account no more than 30 days after receipt of statement or will subject to be turned over to a collections agency within 90 days of my date of service. Should collections become necessary, the responsible party agrees to pay any additional collection fees, and all legal fees of collection without suit, including attorney fees, court costs and filing fees. All returned checks are subject to a $37 Insufficient Fund fee.

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services to include self-pay rates. I have received a "Good Faith Estimate" **explaining how much your medical care will cost.** This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

By signing below, I understand and agree I am electing to undergo a cosmetic procedure at Destin Surgery Center as described in my physician's orders and in my consent for surgery. I understand cosmetic surgery is not considered a medical necessity and therefore, is billed by Destin Surgery Center based on cosmetic self-pay rates for the total operative time used by my physician.

Furthermore, by signing below I understand Destin Surgery Center will not bill my insurance carrier for these services since the procedure I have agreed to undergo is considered an elective encounter for cosmetic surgery and not medically necessary as scheduled by the physician and consented by me. An itemized bill will not be available unless required by state law. **I understand that the amounts I pay under the Cosmetic Self Pay Rate will not be applied to or count toward any deductible or other cost-sharing obligations I may have under my health insurance plan.**

_____	_____	_____
Patient or Patient Representative	**Date**	**Destin Surgery Center Witness**

DA

Destin Anesthesia, LLC

Destin Anesthesia, LLC & Anesthesia Dynamics, LLC

Patient Notice Regarding Anesthesia Services: Anesthesia services are provided at the Destin Surgery Center by *Destin Anesthesia, LLC (DA).* DA contracts and employs certified registered nurse anesthetists, anesthesiologists, and certified anesthesiologist assistants as part of the anesthesia care team. **Anesthesia services will be billed separately from the services of Destin Surgery Center. For anesthesia billing questions or concerns, please call: 1-800-242-5080.**

In the event that *DA/AD* is not a participating provider with your insurance plan, *DA/AD* will work with your insurance carrier through various appeal efforts in order to minimize any penalties or costs that your insurance says that you owe. We are often able to negotiate with your insurer to reduce your out-of-pocket expenses due to *DA/AD* out-of-network status, but we cannot guarantee a result. You will also be required to pay the deductible and/or co-pay amounts determined by your policy/plan.

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to *Destin Anesthesia, LLC (DA) and Anesthesia Dynamics, LLC (AD)* all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of Practice charges for this admission or other amounts as may be provided by an agreement between *DA/AD* and my insurance company. I authorize and direct the insurance company to pay all such benefits to *DA/AD*. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and *DA/AD*.

Authorization to Release Claims Information: I hereby authorize *DA/AD* it employees, contractors, and agents, to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my, the patient's, medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare) or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I hereby authorize *DA/AD* its employees and agents to act on my behalf in completing claims including any appeal process.

Precertification & Financial Responsibility: I understand that my insurer may require compliance with utilization review (UR) program to ensure that plan benefits are justified. I understand that it is the insurer's UR program's responsibility to review proposed elective admissions and anticipated courses of treatment. I understand that if the UR program determines that the admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, healthcare benefits may be withheld. I understand that *DA* is willing to provide professional anesthesia services as requested by my attending physician. I also understand that I may be financially responsible for all related charges incurred as a result of this admission should the UR review program refuse to certify that the admission or a specific service was appropriate or should the certification effort occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company, UR program and personal physician without delay and in advance of my admission.

Cosmetic Self Pay Financial Responsibility: I understand that the Cosmetic Self Pay Rate is based on the cosmetic services I have elected to undergo. The Cosmetic Self Pay Rate is an estimate and is required to be paid in full at the time of service. If additional services or operative time other than those generally included in the agreement are required, I will be responsible for payment of those services. I understand that the DA/AD will not bill my insurance carrier for the services since procedure is cosmetic and elective as scheduled by the physician and consented by me. An itemized bill will not be available unless required by state law. I understand that the amounts I pay under the Cosmetic Cash Pay Rate will not be applied to or count toward any deductible or other cost-sharing obligations I may have under my health insurance plan.

_____

Signature of Patient/Authorized Guardian Signature **Date**