

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

Destin Surgery Center 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

INSURANCE INFORMATION:

Primary Insurance _____

Secondary Insurance _____

Contract # _____

Contract # _____

Policyholders name _____

Policyholders name _____

DOB _____ Relationship to Pt _____

DOB _____ Relationship to Pt _____

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:

	<u>Name:</u>	<u>Telephone</u>
<input type="checkbox"/>	Spouse _____	_____
<input type="checkbox"/>	Caretaker _____	_____
<input type="checkbox"/>	Child _____	_____
<input type="checkbox"/>	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 received a copy of the *Notice of Privacy Practices* and have had the opportunity to review its content.

Patient or Patient Representative

Date

Relationship to Patient

Destin Surgery Center 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, given a paper copy if requested and is the patient, or the patient's personal representative.

PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge I have reviewed 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 a copy of this information as listed in the Patient Rights and Responsibilities.

Patient or Patient Representative

Date

Relationship to Patient

Destin Surgery Center

FINANCIAL AGREEMENT & ASSIGNMENT OF BENEFITS

Prior to your visit our business office will contact your insurance company to verify your eligibility of benefits based on the procedure(s) scheduled by your physician. Depending on your coverage you may be responsible for deductibles, co-insurance, or other out of pocket expenses that are not covered by your health insurance. We will attempt to notify you in advance of your estimated amount due. Payment is expected at time of service unless other arrangements have been made with our staff. You are entitled to an itemized bill per your request unless private pay.

I understand that I am responsible for any charges not paid by my insurer and 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. I agree to pay the Center in accordance with its regular rates and terms. TERMS: Due on date of service unless otherwise indicated. 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 will be subject to an Insufficient Fund fee of \$37.00.

Assignment of Benefits for Insurance Patients

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, workman's comp, private insurance and any other governmental or commercial health/medical plan, to issue payment check(s) directly to Destin Surgery Center for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I authorize Destin Surgery Center to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I understand that I am responsible for any amount not covered by insurance. This assignment will remain in effect until revoked by me in writing.

I certify I have read this document and am the patient or am duly authorized to execute it and accept its terms. I certify I have received verbal and written notice of the content within this document in a language and manner I understand. I have read and have full understanding of the Assignment of Benefits as well as the patient policies and financial policies of Destin Surgery Center.

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? **Please check 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

Relationship to Patient

DA

Destin Anesthesia, LLC

Destin Anesthesia, LLC & Anesthesia Dynamics, LLC
Providing Professional Anesthesia Services for patients at Destin Surgery Center

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* its 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.

Signature of Patient/Authorized Guardian Signature

Date

PATIENT NOTICE REGARDING ANESTHESIA SERVICES

Anesthesia services are provided at the Destin Surgery Center by *Destin Anesthesia (DA)*. *DA* contracts and employees 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.