FLORIDA ORTHOPAEDIC INSTITUTE SURGERY CENTER

OTHER BENEFITS: AUTO, WORKERS' COMPENSATION, ETC.

At the present time, are you receiving any other type of benefits? (e.g. Auto Benefits, Workers' Comp, Black Lung, Veterans Affair, etc.)	YES	NO

STATE OF FLORIDA REPORTING FOR AMBULATORY SURGERY CENTERS

The State of Florida requires Ambulatory Surgery Centers to collect and report patient data. Racial and Ethnical classifications are some of the items reported.

*Please **circle** the classification that best suits your **ethnic** background. ***Hispanic – (of Spanish culture or origin)*** ***Non-Hispanic*** ***Unknown***

*Please **circle** the classification that best suits your **racial** background. ***American Indian/Alaska Native*** ***Asian*** ***Black/African American*** ***White*** ***Other*** ***Unknown***

PATIENT NOTIFICATION

_____ (Patient Initial) - Prior to the date and/or start of my surgical procedure, the following information was provided to me both in writing and verbally:

- Notice of Patient Rights
- Healthcare Advance Directives
- Submission and Investigation of Grievances
- Financial Disclosure
- Estimate of Medical Fees

ASSIGNMENT OF BENEFITS

_____(Patient Initial) - The patient guarantees payment for all charges for this date of service and assigns all insurance benefits to Florida Orthopaedic Institute Surgery Center, LLC. The patient also authorizes release of information as needed to appropriate insurance companies as needed for processing of claims. Patient understands that he/she is financially responsible to Florida Orthopaedic Institute Surgery Center for any charges not covered by insurance. Florida Orthopaedic Institute Surgery Center, LLC is not owned or operated by the Florida Orthopaedic Institute, but owned and operated by a group of physicians affiliated with the Florida Orthopaedic Institute. If the patient has Medicare, he/she certifies the information he/she provided to Florida Orthopaedic Institute Surgery Center for payment under Title XVIII of the Social Security Act is accurate. Patient authorized Florida Orthopaedic Institute Surgery Center to release any information necessary to the Social Security Administration or its carriers to process his/her claim. Patient requests all payments of authorized benefits be made payable to Florida Orthopaedic Institute Surgery Center on his/her behalf. Patient understands he/she is responsible for any deductibles, co-payments or co-insurance set forth by the insurance company.

GUARANTEE OF PAYMENT

_____(Patient Initial) Patient understands and accepts responsibility for payment of all accounts at Florida Orthopaedic Institute Surgery Center. The insurance company will pay some or all of a procedure or an account but it is the responsibility of the patient to see that the account is paid in full.

_____
Printed Name – (Patient, Parent or Legal Guardian)

_____
Witness/Date
(to be signed by a FOISC employee on the day of surgery)

_____
Signature (to be signed on the day of the procedure)