



Completing Your Online Patient Pre-Registration & Medical History

Safety Harbor Surgery Center

3280 N. McMullen Booth Road, Suite 110, Clearwater, FL 33761

(727) 787-3000

Safety Harbor Surgery Center offers patients the convenience and privacy of a secure, online registration process. If you are a new patient to our center, please go online today to complete your registration and Medical History using the login information below. You will be asked about your health history, medications, and previous surgeries. It's important to complete your online registration as soon as possible so that your medical team will have time to review your information prior to your visit. We will call you if we have any questions or concerns.

Here are the simple steps for completing your **MEDICAL HISTORY** online for One Medical Passport and registration forms:

1. Go online to [www. safetyhARBORSURGERYCENTER.COM](http://www.safetyhARBORSURGERYCENTER.COM).
2. Click "REGISTER HERE" on the left side of the main page.
3. Click on the green 'Register' button to create a medical passport.
4. Follow the prompts and set up your account's username and password.
5. Answer the questions on each page then click 'Save & Continue' on each page.
6. Once complete, click 'Finish' to submit your health history.

IF THIS IS YOUR FIRST VISIT TO SAFETY HARBOR SURGERY CENTER OR IT HAS BEEN LONGER THAN A YEAR SINCE YOUR LAST VISIT YOU MUST COMPLETE THE ONE MEDICAL PASSPORT PRE-VISIT MEDICAL SCREENING AND REGISTRATION ONLINE WITH ANY COMPUTER, TABLET OR SMART PHONE.

If you have previously used One Medical Passport at any other medical facility, please use that log in.

Thank you in advance for completing your online registration and Medical History. This information will help us give you the best medical care possible. We look forward to seeing you soon!

Physician Name: _____ Procedure Date: _____

In order to provide you with excellent care and minimize long phone interviews and paperwork, Safety Harbor Surgery Center asks that you complete a Medical Passport, an online registration form that allows patients to provide complete, accurate medical information to their team in order to provide a safe and optimal patient-care experience. You may also receive a phone call, email, or text from One Medical Passport directing you to complete your medical history.

How to Complete Your Medical Passport

Go to www.SafetyHarborSurgeryCenter.com, and click on the "Register Here" button to be connected with One Medical Passport, or scan the QR code and follow the instructions below:



Username

Password


First Time Users:

Click on the green 'Register' button to create a medical passport. Follow the prompts and set up your account's username and password which you may document on this paper if needed. Answer the questions on each page then click 'Save & Continue' on each page. Once complete, click 'Finish' to submit your health history.



Returning Users :

If you have previously created a Medical Passport & are having another procedure, you will need to verify and/or update your information. Enter your previous username & password in the 'Welcome Back' area and click 'Sign In' then locate the *purple button* to update your health history.



Need Help?

On the top right hand corner of each page, there's a Help link you may click on for assistance. If you are unable to complete your medical history online, a pre-admission nurse from our facility will contact you by phone close to the date of your procedure to complete your history with you.

Please note that questions regarding arrival or procedure time, billing/co-pays, pre-procedure instructions or medical concerns/test results must be directed to your physician's office or the facility directly.

SAFETY HARBOR SURGERY CENTER
PREPARING FOR SURGERY OR YOUR PROCEDURE
A Patient's Guide to Frequently Asked Questions

Where do I go the day of surgery?

Safety Harbor Surgery Center. The physical address is as follows:
3280 North McMullen Booth Road
Suite 110
Clearwater, Florida 33761
Phone: 727.787.3000 for directions.

The surgery center is on the 1st floor of a two-story building. The suite is 110, just to the left as you come through the main entrance of the building. The receptionist is just inside the surgery center entrance. Our hours of operation are from 7:00 am to 5:00 pm. Our building door is open at 6:00am if your scheduled arrival time is before 7:00am.

How late can I eat or drink before my surgery? Can I brush my teeth the morning of my procedure?

DO NOT eat or drink anything after midnight the evening prior to your procedure unless instructed by your physician or preoperative nurse. If you have a history of Gastroparesis, please start clear liquids 48 hours (2 days) prior to your procedure, then do not eat or drink anything after midnight the evening prior to your procedure unless instructed by your physician. It is very important that you follow the provided instructions. If you do not, your surgery may be delayed or cancelled. You should also refrain from chewing gum and smoking. You may brush your teeth but do not swallow.

Do I take my medication the morning of the procedure?

Take your blood pressure medication, heart medication, thyroid medication, steroid medication, Parkinson medication and anti-seizure medication the morning of surgery before you come to the surgery center with a small sip of water. All others should be held. For diabetics, you need to hold all oral diabetic medication the morning of surgery. If on insulin injections you should take half the evening dose of the insulin and do not take the morning of surgery (unless told otherwise by your doctor). For patients using an insulin pump, the basal infusion should be turned off upon arrival to surgery center. All diuretics must be held morning of surgery i.e. Lasix(furosemide), hydrochlorothiazide, Bumex(bumetanide), aldactone(spironolactone).

*****Blood thinners**** please see list below for discontinuation dates.

*******All ophthalmology (eye) patients Do Not need to stop any blood thinners.**

Blood Thinner/ Anticoagulant Discontinuation

Plavix (clopidogrel)- 5 days

Eliquis (dabigatran), Xarelto (rivaroxaban)- 48hrs

Coumadin (warfarin)- 5days ** Need INR prior to surgery- call your physician to order lab test

Effient (prasugrel), Brilinta (ticagrelor)- 7 days

Aspirin-5 days

Pradaxa – 5 days

*******For above: please confirm and coordinate with your Physician or Cardiologist that you may come off of these medications.**

NSAIDS/SUPPLEMENTS- 5 days (Advil, Ibuprofen, Aleve, Meloxicam, Diclofenac, excedrin, Naproxen, Fish Oil, Vitamin E).

OZEMPIC: hold for one week prior to surgery.

What should I bring with me and what should I wear to the surgery center?

Bring only what is needed for your comfort and only what is requested by the facility. Wear clothing that is easy to slip on and off. Consider bringing a sweater if you or your visitor are easily chilled. Unless you have a financial responsibility, leave money and credit cards home. Leave all jewelry (includes body piercings) and other valuables at home. However, please bring your identification card, insurance card, and payment if necessary. If you wear dentures or hearing aids, you may wear them to the surgery center; however, you may be asked to remove them before your procedure. Refrain from perfume or cologne as it may affect other patients that may be sensitive to the smells. Refrain from makeup, deodorant, and lotion as well. Patients are allowed to bring cell phones and are highly encouraged to do so, however no photos or videos are allowed.

What will happen once I go to the area to prepare for my procedure?

You will be taken to an area called pre-op. Here you may change into a gown. You will be placed in a stretcher or in a chair in your own area with curtains to help protect your privacy. You will be attached to a monitor to observe your blood pressure, heart rate, respirations and temperature. Your pre-op nurse will review your health history, medications, allergies, the procedure you are having and the name of your physician. These questions will be asked by all your healthcare providers prior to your procedure. This will be of a repetitive nature. This is not to annoy but **is for your safety** and to protect you from harm. Once settled by your nurse in pre-op, you will then meet your anesthesia and operating room team.

Your pre-op nurse will complete the necessary documents with you to get you ready. If procedure requires sedation, you may have an intravenous (IV) line started before you are taken to your procedure. This is a catheter that is inserted into a vein and used for fluids, hydration, and medications which you will receive for your procedure. The fluid used is water with nutrients. If your procedure requires anesthesia, your medications will be given through your IV. Once you are prepared, you will be taken into the operating room.

What happens when I go to the Operating or Procedure Room?

You will meet your Procedure team at your bedside in pre-op and your procedure will be reconfirmed. You will be taken into the operating room by your team and you may be asked to move to another bed in the room. You will receive warm blankets. An Anesthesia Caregiver will place the monitor leads on you, provide you with oxygen through a plastic tube under your nose, and give you medications through your IV to make you relax or sleep. You will be told when this happens. Once your procedure is finished, you will be taken to the recovery room.

What happens in the recovery room?

After you wake up, you may stay in recovery 15 to 60 minutes or longer, depending on your needs, or you may recover in a recliner for 15-30 minutes. Let the nurse know if you experience any pain or nausea. You will be given something to drink to check your tolerance of fluids. Your nurse will review with you and your Significant Other your discharge instructions written by your doctor, for you at home. This is the time to ask any questions. A member of the staff will call you the next day to see how you are feeling.

Can visitors come with me?

Family members and friends are welcome in the facility to accompany you. For patient safety, exceptions may be made on days with multiple physicians where space may be limited. We may ask family to wait in waiting room or separate area. There is a main lobby in the building where your family member, friend or driver may sit during your procedure. It is our preference that family members, friends, and/ or drivers stay for the duration of your procedure on the premises. Family members and friends are welcome to sit in their cars or go home or run errands if they stay within 30 minutes of the Surgery Center. We ask that a number is provided for your family member, friend, or driver so that we may reach them. In the instance that you need assistance with paperwork, dressing or undressing, or any other needs a member from the surgery center will be happy to assist you. If it is necessary for you to have someone with you, please discuss this need with our staff and we can make accommodations for your special request.

Can I drive myself home after my procedure?

No. You will need to arrange for someone to drive you home. If you do not have a ride home and caregiver for 1st 24hr then your procedure will be cancelled. Uber/Lift/taxi transportation is not permitted by yourself. It is only allowed if have a family member/visitor with you to accompany in the vehicle home.

You will also need to arrange to have a caregiver with you for 24 hours after receiving anesthesia for your procedure.

If you have any questions regarding surgery preparation, please call the surgery center at 727.787.3000.

If you have any questions regarding your procedure, prescriptions, or after care instructions, please contact your physician.

If you have a medical emergency once you are discharged, please immediately pick up the phone and call 9-1-1.

What costs will I incur for my procedure?

You will receive an estimate of the amount due for the facility fee based off your insurance benefits, which is due at time of service. **Insurance Disclaimer:** “A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member’s contract at time of service.”

You may also receive additional bills from the surgeon’s office, the anesthesia group, pathology, physician assistant and/or medical supply companies.

Please be advised that Anesthesia Management Solutions may not be contracted with your insurance carrier. Please call 1-866-653-2540 to verify if they are participating with your insurance prior to your scheduled procedure.



**For Anesthesia billing questions, contact Anesthesia Management Solutions at:
1.866.653.2540**

We know you have options when choosing a physician for your healthcare needs, and we thank you for having your procedure performed at our center. Anesthesia is commonly a covered component of your procedure. The bill/claim for your anesthesia services will be filed directly to your primary insurance carrier, then to your secondary insurance carrier after primary payment, if applicable. We have accepted assignment of benefits and your insurance carrier should send the payment directly to our remittance address.

We strive to resolve your claims without your involvement, and optimally, leave you with little or zero out-of-pocket expense, but, in some cases, we may request your assistance as the original patient letter you signed on your procedure date indicated and expressed. **Under no circumstances will you be billed for the out-of-pocket responsibility listed on an "Out of Network" EOB.**

What should you expect:

1. You will receive an Explanation of Benefits (EOB) from your insurance carrier with a "patient responsibility" amount.
2. Do not pay based on the EOB but rather wait until you receive a statement **AFTER** we have resolved your balance due.
3. Should you receive a payment for the services provided directly from the insurance carrier:
 - a. Forward a copy of the Explanation of Benefits (EOB) that you received via email to Patients@VBRCM.com.
 - b. Send the check(s) and a copy of the EOB that you received or mail a personal check to:
AMS National LLC
PO Box 919473
Orlando, FL 32891-9473
 - c. Should you receive any additional checks or EOBs, please follow the steps above.
4. Once you received your statement for services following the resolution by your insurance carrier, please pay the bill in full or contact our office to make other payment arrangements.
5. If there are any changes in your insurance, please contact our office immediately.

Assignment of Benefits and Authorization to Appeal: I authorize payment of medical benefits to Anesthesia Management Solutions (AMS). I understand that the only charges that I may be responsible for are those charges assigned as "patient responsibility" by my insurance carrier or other third-party payer or when I have no insurance or third-party coverage. I agree to immediately remit to AMS any payments that I receive directly for services provided. I hereby authorize release of any medical records or information necessary to process insurance claims, appeal benefit determinations, coverage denials, or other adverse decisions on my behalf.

HIPAA Notice: Please note that AMS, the facility and Value-Based RCM (VBRCM) are Business Associates. As a result, each entity may receive, use, obtain, access, or create Protected Health Information in the course of providing anesthesia service and affiliated business processes. In order to ensure your privacy and protection, please carefully read the HIPAA information you have been provided.

Patient/Guarantor Signature

Date

PATIENT LABEL



AMS NATIONAL
PO BOX 919473
ORLANDO, FL 32891-9473
Tel: 866.653.2540
Fax: 941.315.5743

For any anesthesia billing questions, please contact us at 866.653.2540

AMS is the anesthesia provider group that will be ensuring your safety and comfort for your upcoming procedure, and we are happy to be a part of your trusted health care team. You are receiving this letter because your surgeon or healthcare facility has indicated that you will be responsible for reimbursement of anesthesia fees for this procedure, and we want to help you resolve your obligation as easily as possible.

Because AMS will not be billing insurance for your procedure, and because we have structured our fees to make it simple to know the out-of-pocket expense for anesthesia services, we would appreciate if you can pay in advance for the communicated amount owed. Either your surgeon or your healthcare facility should be able to tell you the fees, or you can call us at the number above.

We have two simple ways to pay for your anesthesia services:

1. Remit payment via check to the address above – please include the following information with your payment so we can appropriately credit your account: Patient Name, Date of Procedure, Surgery Center/Hospital Name, Surgeon Name.
2. For prepayment via credit or debit card (Visa, Mastercard, Discover, American Express), use our secure payment website: <https://www.epayitonline.com>. You will enter codeID 038830865 and Access # 9 – 1 – 2 in the appropriate boxes, fill out the required fields as prompted, and submit your payment. We will receive that payment and reconcile to your account after services are provided.

For your security, we will not accept credit card, debit card, or checking account echeck payments over the phone. However, if you have any questions about this process, please contact us at the number above.

We hope that providing these options to satisfy the financial obligation of your procedure gives you the opportunity to focus on your health and recovery.

Please note that your healthcare facility and AMS are business associates. As a result, AMS may receive, use, obtain, access, or create Protected Health Information from or on behalf of your healthcare facility in the course of providing anesthesia services. To ensure your privacy and protection, please carefully read the HIPAA information provided to you by your service location.

Thank you for the opportunity to provide excellent clinical care to you, and we strive to provide excellent billing and customer service after your services are complete. Our goal is 100% satisfaction, and we urge you to contact us if we have not met your expectations.

Sincerely,

Anesthesia Management Solutions – AMS
866.653.2540

Guest Registration Information

Have you ever been a patient at the Safety Harbor Surgery Center in the past? YES NO

Patient Name: _____
Last First M.I.
Date of Birth: _____ Soc. Security Number: _____ Male Female

Complete Address: _____

City, State, ZIP _____ Home Phone # () _____

Cellular Phone # () _____ Work Phone # () _____

Email: _____ (This will only be used for your online patient satisfaction survey)

Race: (circle one) Black White Asian Hispanic Other _____

(For our female guests)

Is there a chance that you may be pregnant? YES NO

Last menstruation Period _____ Estimated Due Date _____

**** GUARANTOR INFO (ONLY complete if the patient is a minor (under 18 yrs) or incapacitated adult)****

Name of Guarantor _____ Soc Security # _____

Guarantor's Date of Birth _____ Relationship to patient _____

Address (only if different than patient) _____

City, State, Zip _____ Home Phone # () _____

**** INSURANCE SUBSCRIBER INFO (complete ONLY if sub on the insurance policy is not the patient)****

AName of Subscriber _____ Soc. Security # _____

Relationship to Guarantor _____ Spouse _____ Parent _____ Other _____ Date of Birth _____

**** ACCIDENT INFO (please complete if service we are providing to you today is the result of an accident)****

Worker's Comp _____ Auto Accident _____ Other _____

Date of Accident or Injury (day, month, year) _____ Claim # _____

Name of Insurance carrier, claims address, phone number and name of adjuster handling the claim:

Medicare Secondary Payer Questionnaire (Short Form)

1. Are you receiving benefits from any of the following programs?

Black Lung	<input type="checkbox"/> No <input type="checkbox"/> Yes
Research Grant	<input type="checkbox"/> No <input type="checkbox"/> Yes
Veteran Affairs	<input type="checkbox"/> No <input type="checkbox"/> Yes

2. Was the illness/injury due to a work related accident/condition?

☐ No ☐ Yes

Date of injury/illness: _____

3. Was illness/injury due to a non-work related accident?

☐ No ☐ Yes

Date of accident: _____

What type of accident caused the illness/injury?

☐ Automobile
☐ Non-automobile

4. Are you entitled to Medicare based on:

☐ Age
☐ Disability
☐ End Stage Renal Disease

5. Are you currently employed?

☐ No ☐ Yes

6. Is your spouse currently employed?

☐ No ☐ Yes

7. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?

☐ No ☐ Yes

8. Does the employer that sponsors your GHP employ 20 or more employees?

☐ No ☐ Yes

9. Are you currently a patient in a skilled nursing facility such as a nursing home?
(Long form not required. ALERT: If yes, bill SNF not Medicare)

☐ No ☐ Yes

I confirm that the above information is correct.

Patient Signature: _____

Date: _____

Please Print Name: _____

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # _____

Work # _____

Mobile # _____

Other _____

Place Patient Identification Label Here

E-Mail Communication Preferences

Email Address _____

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 Safety Harbor 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 on an answering device. If an email address has been provided, Safety Harbor Surgery Center or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

Mail Communication Preferences

May we send mail to your home address? (If no, please provide an alternate mailing address below.)

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

<u>Name:</u>	<u>Telephone</u>
<input type="checkbox"/> Spouse _____	_____
<input type="checkbox"/> Caretaker _____	_____
<input type="checkbox"/> Child _____	_____
<input type="checkbox"/> Parent _____	_____
<input type="checkbox"/> Other _____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

Patient or Personal Representative Signature

Date

Printed Name

Relationship to Patient



NOTICE OF PRIVACY PRACTICES

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.

Who Presents this Notice

The references to "Facility" and "Health Professionals" in this notice refer to the members of the United Surgical Partners International Affiliated Covered Entity. An Affiliated Covered Entity (ACE) is a group of organizations under common ownership or control who designate themselves as a single Affiliated Covered Entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The Facility, its employees, workforce members and members of the ACE who are involved in providing and coordinating health care are all bound to follow the terms of this Notice of Privacy Practices ("Notice"). The members of the ACE will share PHI with each other for the treatment, payment and health care operations of the ACE and as permitted by HIPAA and this Notice. For a complete list of the members of the ACE, please contact the Privacy & Security Compliance Office.

Privacy Obligations

Each Facility is required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. The Facility uses computerized systems that may subject your Protected Health Information to electronic disclosure for purposes of treatment, payment and/or health care operations as described below. When the Facility uses or discloses your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

Notifications

The Facility is required by law to protect the privacy of your medical information, distribute this Notice of Privacy Practices to you, and follow the terms of this Notice. The Facility is also required to notify you if there is a breach or impermissible access, use or disclosure of your medical information.

Permissible Uses and Disclosures Without Your Written Authorization

In certain situations your written authorization must be obtained in order to use and/or disclose your PHI. However, the Facility and Health Professionals do not need any type of authorization from you for the following uses and disclosures:

Uses and Disclosures for Treatment, Payment and Health Care Operations. Your PHI may be used and disclosed to treat you, obtain payment for services provided to you and conduct "health care operations" as detailed below:

Treatment. Your PHI may be used and disclosed to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, you may be contacted to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be

of interest to you. Your PHI may also be disclosed to other providers involved in your treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because if you do, this may impact your recovery.

Payment. Your PHI may be used and disclosed to obtain payment for services provided to you—for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care (“Your Payor”) to verify that Your Payor will pay for health care. The physician who reads your x-ray may need to bill you or your Payor for reading of your x-ray therefore your billing information may be shared with the physician who read your x-ray.

Health Care Operations. Your PHI may be used and disclosed for health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you. For example, PHI may be used to evaluate the quality and competence of physicians, nurses and other health care workers. PHI may be disclosed to the Privacy & Security Compliance Office in order to resolve any complaints you may have and ensure that you have a comfortable visit. Your PHI may be provided to various governmental or accreditation entities such as the Joint Commission on Accreditation of Healthcare Organizations to maintain our license and accreditation. In addition, PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of the Facility and Health Professionals.

Additionally, your PHI may be used or disclosed for the purpose of allowing students, residents, nurses, physicians and others who are interested in healthcare, pursuing careers in the medical field or desire an opportunity for an educational experience to tour, shadow employees and/or physician faculty members or engage in a clinical Practicum.

Health Information Organizations. Your PHI may be used and disclosed with other health care providers or other health care entities for treatment, payment and health care operations purposes, as permitted by law, through a Health Information Organization. A list of Health Information Organizations in which this facility participates may be obtained upon request or found on our website at www.uspi.com. For example, information about your past medical care and current medical conditions and medications can be available to other primary care physicians if they participate in the Health Information Organization. Exchange of health information can provide faster access, better coordination of care and assist providers and public health officials in making more informed treatment decisions. You may opt out of the Health Information Organization and prevent providers from being able to search for your information through the exchange. You may opt out and prevent your medical information from being searched through the Health Information Organization by completing and submitting an Opt-Out Form to registration.

Use or Disclosure for Directory of Individuals in the Facility. Facility may include your name, location in the Facility, general health condition and religious affiliation in a patient directory without obtaining your authorization *unless* you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or minister, even if they do not ask for you by name. If you do not wish to be included in the facility directory, you will be given an opportunity to object at the time of admission.

Disclosure to Relatives, Close Friends and Other Caregivers. Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you who is involved in your health care or helps pay for your care. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the

Facility and/or Health Professionals may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, the Facility and/or Health Professionals would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Health Oversight Activities. Your PHI may be disclosed to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. For example, your PHI may be disclosed to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the facility.

Correctional Institution. Your PHI may be disclosed to a correctional institution if you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain requests to us.

Organ and Tissue Procurement. Your PHI may be disclosed to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Research. Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board approves a waiver of authorization for disclosure.

Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

U.S. Military. Your PHI may be used or disclosed to U. S. Military Commanders for assuring proper execution of the military mission. Military command authorities receiving protected health information are not covered entities subject to the HIPAA Privacy Rule, but they are subject to the Privacy Act of 1974 and DoD 5400.11-R , "DoD Privacy Program," May 14, 2007.

Other Specialized Government Functions. Your PHI may be disclosed to units of the government with special functions, such as the U.S. Department of State under certain circumstances for example the Secret Service or NSA to protect the country or the President.

Workers' Compensation. Your PHI may be disclosed as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of a medical device.

Appointment Reminders. Your PHI may be used to tell or remind you about appointments.

Fundraising. Your PHI may be used to contact you as a part of fundraising efforts, unless you elect not to receive this type of information.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Use or Disclosure with Your Authorization. For any purpose other than the ones described above, your PHI may be used or disclosed only when you provide your written authorization on an authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before your PHI can be sent to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

Marketing. Your written authorization ("Your Marketing Authorization") also must be obtained prior to using your PHI to send you any marketing materials. (However, marketing materials can be provided to you in a face-to-face encounter without obtaining Your Marketing Authorization. The Facility and/or Health Professionals are also permitted to give you a promotional gift of nominal value, if they so choose, without obtaining Your Marketing Authorization). The Facility and/or Health Professionals may communicate with you in a face-to-face encounter about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without Your Marketing Authorization.

In addition, the Facility and/or Health Professionals may send you treatment communications, unless you elect not to receive this type of communication, for which the Facility and/or Health Professionals may receive financial remuneration.

Sale of PHI. The Facility and Health Professionals will not disclose your PHI without your authorization in exchange for direct or indirect payment except in limited circumstances permitted by law. These circumstances include public health activities; research; treatment of the individual; sale, transfer, merger or consolidation of the Facility; services provided by a business associate, pursuant to a business associate agreement; providing an individual with a copy of their PHI; and other purposes deemed necessary and appropriate by the U.S. Department of Health and Human Services (HHS).

Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental illness, mental retardation and developmental disabilities; (3) is about alcohol or drug abuse or addiction; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about communicable disease(s),

including venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult; or (9) is about sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, the Facility and Health Professionals are not required to agree to these requested restrictions.

You may also request to restrict disclosures of your PHI to your health plan for payment and healthcare operations purposes (and not for treatment) if the disclosure pertains to a healthcare item or service for which you paid out-of-pocket in full. The Facility and Health Professionals must agree to abide by the restriction to your health plan EXCEPT when the disclosure is required by law.

If you wish to request additional restrictions, please obtain a request form from the Health Information Management Office and submit the completed form to the Health Information Management Office. A written response will be sent to you.

Right to Receive Confidential Communications. You may request, and the Facility and Health Professionals will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the Facility and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Facility Health Information Management Office identified below.

Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by the Facility and Health Professionals in order to inspect and request copies of the records. Under limited circumstances, you may be denied access to a portion of your records. If you desire access to your records, please obtain a record request form from the Facility Health Information Management Office and submit the completed form to the Facility Health Information Management Office. If you request copies of paper records, you will be charged in accordance with federal and state law. To the extent the request for records includes portions of records which are not in paper form (e.g., x-ray films), you will be charge the reasonable cost of the copies. You also will be charged for the postage costs, if you request that the copies be mailed to you. However, you will not be charged for copies that are requested in order to make or complete an application for a federal or state disability benefits program.

Right to Amend Your Records. You have the right to request that PHI maintained in your medical record file or billing records be amended. If you desire to amend your records, please obtain an amendment request form from the Facility Health Information Management Office and submit the completed form to the Facility Health Information Management Office. Your request will be accommodated unless the Facility and/or Health Professionals believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, you will be charged for the accounting statement.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Privacy & Security

Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy & Security Compliance Office will provide you with the correct address for the Director. The Facility and Health Professionals will not retaliate against you if you file a complaint with the Privacy & Security Compliance Office or the Director.

Effective Date and Duration of This Notice

Effective Date. This Notice is effective on March 1, 2021.

Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that the Facility and Health Professionals maintain, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas around the Facility and on our Internet site at www.uspi.com. You also may obtain any new notice by contacting the Privacy & Security Compliance Office.

FACILITY CONTACTS:

Privacy & Security Compliance Office
14201 Dallas Parkway
Dallas, Texas 75254
E-mail: PrivacySecurityOffice@tenethealth.com
Ethics Action Line (EAL): 1-800-8-ETHICS

Notice of Privacy Practices Acknowledgment Form

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices 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 Notice of Privacy Practices and is the patient, or the patient's personal representative.

Name of Patient

Signature of Patient

_____/_____/_____
Date Signed

Name Patient's Personal Representative

Signature of Patient's Personal Representative

_____/_____/_____
Date Signed

FOR INTERNAL USE ONLY

Name of Employee

Signature of Employee

If applicable, reason patient's written acknowledgment could not be obtained:

- ☐ Patient was unable to sign.
☐ Patient refused to sign.
☐ Other _____

__5 (Version: As noted on NPP)

1/ 1/ 2017 (Date: As noted on NPP)

**NOTICE OF PRIVACY
PRACTICES (NPP)**

P
A
T
I
E
N
T

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or provider.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right 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.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

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

ADVANCE DIRECTIVE NOTIFICATION

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. **Safety Harbor Surgery Center** respects and upholds those rights.

Our team is dedicated to delivering the highest quality care in a safe environment that places the patient at the center of our care. We respect your rights to participate in make decisions regarding your care and self-determination and will carefully consider your requests. After careful consideration and reviewing the applicable state regulation, the leadership of the facility has established a policy to initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. The majority of procedures performed at **Safety Harbor Surgery Center** are considered to be of minimal risk, hence the risk of you needing such measures are highly unlikely. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your 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, you choose to proceed with your procedure at **Safety Harbor Surgery Center**

If you wish to complete an Advance Directive, copies of the official State forms are available at our facility.

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

PATIENT COMPLAINT OR GRIEVANCE

To report a complaint or grievance you can contact the facility Administrator by phone at **727-787-3000** or by mail at:

**Safety Harbor Surgery Center
3280 North McMullen Booth Road, Suite 110
Clearwater, FL 33761-2009**

Complaints and grievances may also be filed through:

Agency for Healthcare Administration

2727 Mahan Drive
Tallahassee, FL 32308
1 (888) 419-3456

Medicare beneficiaries may receive information regarding their options under Medicare and their rights and protections by visiting the website for Office of the Medicare Beneficiary Ombudsman <http://www.ombudsman.ed.gov/about/contactus.html>

Visit the web site listed above or call 1-800-MEDICARE (1-800-633-4227) for more information, to ask questions, and to submit complaints about Medicare to the Office of the Medicare Ombudsman. TTY users should call 1-877-486-2048.

Report a Patient Safety or Quality of Care Event:

Office of Patient Safety or Quality of Care Event:

The Joint Commission

One Renaissance Boulevard

Oakbrook, Illinois 60181

Email: patientsafetyreport@jointcommission.org

Fax: (630) 792-5636

<https://apps.jointcommission.org/QMSInternet/IncidentEntry.aspx>

Submit and update your concern with your incident number:

<https://apps.jointcommission.org/QMSInternet/IncidentUpdate.aspx>

Safety Harbor Surgery Center, LLC

Patient Agreement and Consent

1. **CHOICE IN HEALTHCARE FACILITIES:** You have healthcare choices. These are a few alternative facilities available to you:

Mease Countryside Hospital
3231 McMullen Booth Road
Safety Harbor, Florida 34695
(727) 725-6111

Mease Dunedin Hospital
601 Main Street
Dunedin, Florida 34698
(727) 733-1111

Morton Plant Hospital
300 Pinellas Street
Clearwater, Florida 33756
(727) 462-7000

2. **CONSENT TO TREATMENT:** I hereby authorize the physician in charge of my care the Surgery Center to provide services including, but not limited to, emergency medical services, routine, diagnostic procedures, and medical procedures as their judgment may deem necessary or advisable. I acknowledge that any physicians and surgeons furnishing services to me including, but not limited to, radiologists, anesthesiologists, and pathologists are independent contractors with me and are not employees, agents or servants of the Surgery Center. I further understand that I am under the care and supervision of my surgeon and that it is my surgeon's sole responsibility to obtain my informed consent when required for medical, surgical, diagnostic, or therapeutic procedures, or facility services rendered to me under the general or special instructions of my surgeon.
3. **AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** I hereby authorize the Surgery Center and/or any treating physicians, and my insurance company to obtain, or my attorney, use and/or release information (current and historical) for the purposes of treatment, payment, and/or operations, as outlined in the Notice of Privacy Practices. This may include collection agencies, credit bureaus, and myself, and will be limited to the minimum amount necessary.
4. **MEDICARE/ MEDIGAP/ MEDICAID PATIENT CERTIFICATION/ RELEASE OF INFORMATION AND PAYMENT REQUEST:** I certify that the information given to apply for payment under Title XVIII and/or Title XIX, of 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. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare, Medigap or Medicaid for payment. I understand that I am responsible for any health insurance deductibles and co-payments.
5. **ASSIGNMENT OF INSURANCE BENEFITS AND GUARANTEE OF PAYMENT:** I hereby authorize, request and direct any and all assigned insurance companies to pay directly to the Surgery Center and/or my treating physician the amount due me in my pending claims for facility benefits under the respective policies. For value received, including but not limited to the services rendered, I agree to guarantee and promise to pay the Surgery Center and any treating physicians, all charges and expenses incurred in my treatment, including those expenses not covered by any insurance policy presently in force, including any co-payment and/or deductible. I understand that the Surgery Center will provide me with an

estimate of charges prior to my procedure. Unless specifically agreed in writing, all charges shall be paid prior to your procedure. Unpaid accounts shall bear interest at the rate provided by law, whether suit is brought or appeal taken. If any action at law or in equity is brought to enforce this agreement, the facility and/or treating physicians shall be entitled to recover attorney's fees, court costs, and any other costs of collection incurred.

6. **RELEASE OF RESPONSIBILITY AND LIABILITY FOR PERSONAL VALUABLES:** I understand that the Surgery Center discourages retaining personal valuables while at the center and agree that the Surgery Center is not responsible for valuables or belongings brought into the facility. Personal valuables or belongings include, but are not limited to, clothing, dentures, glasses, prosthetic devices (such as hearing aids, artificial limbs, or assist devices such as: canes, walkers, or wheelchairs), credit cards, jewelry and money.
7. Your physician may be an owner in Safety Harbor Surgery Center, LLC. Owners include: Dr. Umesh Choudhry; Dr. Dana Deupree; Dr. Theodore Small; Dr. Robert Davidson; Dr. Satinderpal Sondhi; Dr. Gourisankar Degala; Dr. Michael Manning; Dr. Robert Roth; Dr. Aaron Davis; Dr. Lee Ann Brown; Dr. George Panagakos; Dr. Martin Richman; Dr. Lonnie Klein and Dr. Paulas Vyas.

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS DOCUMENT HAS BEEN READ BY OR EXPLAINED TO ME AND I UNDERSTAND THIS INFORMATION. I WILL RECEIVE A COPY OF THIS DOCUMENT UPON REQUEST. I ACKNOWLEDGE THAT A COPY OF THIS DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.

Patient Signature: _____ Date: _____

Signature of Patient's Authorized Representative: _____

Relationship to Patient: _____

Surgery Center Representative: _____