Patient Registration:

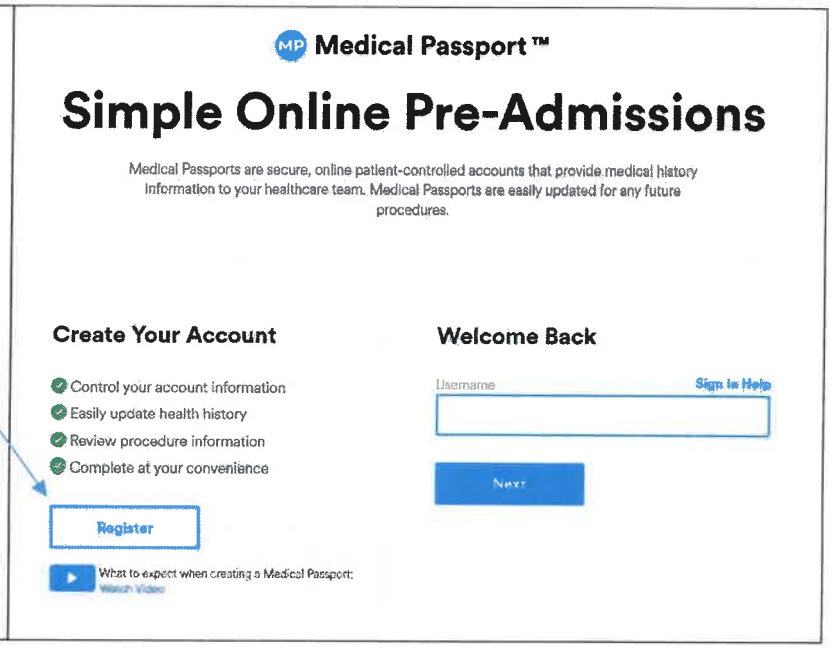
To ensure you receive the best care possible, Safety Harbor Surgery Center offers patients the convenience and privacy of a secure, online registration process. If you are a new patient to our center, please go online today to complete your registration and Medical History using the login information 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. **For your safety, if you do not complete your medical history, your procedure may be cancelled.**

How to complete your MEDICAL HISTORY online:

1. Go to our facility web site: www. safetyharborsurgerycenter.com.
2. Click the blue "REGISTER HERE" which is located below the facility picture.
3. Click on the "Start Now" button to create a medical passport.
4. Follow the prompts to start your account's username and password.
5. Answer the questions on each page then click 'Save & Continue' on each page. If you need assistance, click the Help link located on every page or call the Help Line at 1-800-540-7527: leave a message, and someone will call you back.
6. Once complete, click 'Finish' to submit your health history.

New patients click the blue Register to create an account.

Returning patients enter username and password to update your information for your procedure. If you have previously used *One Medical Passport* at any other medical facility, please use that log in.



Dear Patient:

Much information is located on our web site, including the Patient Bill of Rights, Advanced Directives, Physician Ownership, and who to contact with a complaint or grievance. If you would like, we will also provide copies of these upon your arrival. 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!

Before Your Surgery:

- **Our goal is for patients to have a safe discharge home. YOU MUST** arrange for a responsible adult to drive you home after your procedure, and make accommodations for someone to stay with you for 24 hours, or the procedure will be rescheduled. For your safety, we will not allow patients to be discharged via Uber, Lyft, or taxi unless a responsible adult accompanies you.
- The Surgery Center is located 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 building door is open at 6:00 a.m. if your scheduled arrival time is before 7:00am.
- **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 at 12 noon the day before 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.
- 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 hold all blood thinners for 5 days. **All ophthalmology (eye) patients *Do Not* need to stop any blood thinners.** 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, MOUNJARO, TRULICITY, WEGOVY, ZEPBOUND, TRIZEPITIDE: hold for one week prior to surgery.
- VICTOZA, RYBELSUS, SAXENDA: hold for 3 days prior to surgery.

What to Expect on the Day of Surgery:

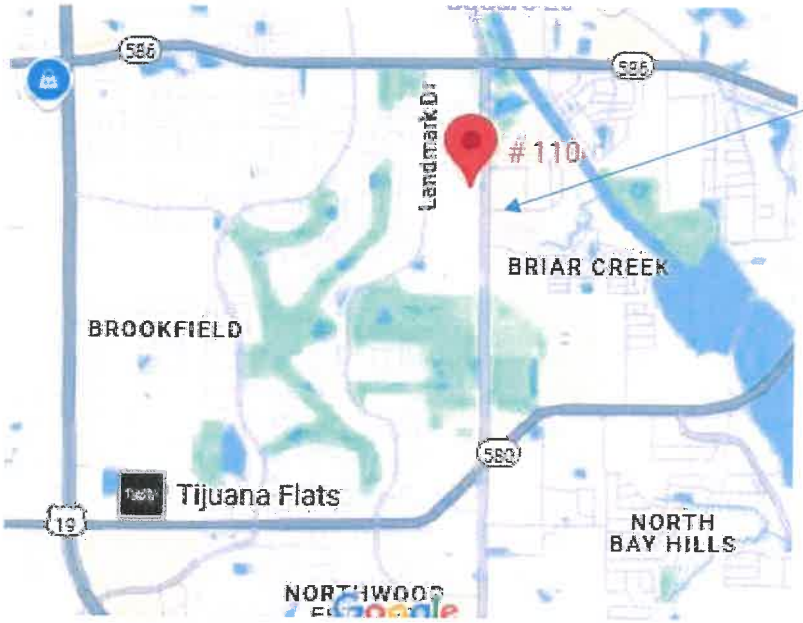
- Arrive promptly at the time we give you (you will receive a phone call the day prior between 11:00 – 2:00 with your arrival time).
- Bring a copy of your identification, insurance cards, and methods of payment. Leave all other valuables at home. All jewelry and body piercings must be removed prior to surgery.
- You may bring your cell phone. 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.
- Please bathe the evening before or the morning of your procedure; this will decrease your risk of infection. Wear comfortable warm clothing, and please have your significant others dress warm or bring a sweater.
- Upon arrival, and throughout your visit, you will be asked for verification of your name, birthdate, procedure, allergies, and home medications.
- You will be taken to the pre-procedure area where our team will continue preparing you for your procedure.
- You will be asked to sign a consent form, which verifies that you and your doctor have discussed the surgery to be performed as well as the risks. Depending on the type of procedure you are having, the physician will mark that area on your body.
- Once you are taken to the procedure room, the team in the room will again verify with you the correct procedure and the correct site.

After Your Surgery:

- You may expect to be in our recovery area for approximately 15 minutes to an hour depending on the type of procedure you are having.
- You will be given verbal and written instructions for your care at home. In the event of any difficulty at home, call your surgeon or go to the nearest emergency room. If you experience a medical emergency please call 9-1-1.
- A nurse will call you the following day to see how you are doing and answer any questions you may have. We will be texting/emailing you a brief survey to fill out after your procedure.

Financial Information:

- You can expect to receive a call from a business office team member to discuss your financial responsibility 3-5 days prior to our scheduled day of surgery or text message from *One Medical Passport*.
- 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."
- Deductibles, coinsurance and co-pays will be collected upon your arrival to the center. We accept all major credit cards, cash, check and Care Credit.
- After your procedure, we will submit your bill to your insurance company.
- **You may also receive additional bills from the surgeon's office, the anesthesia group, pathology, physician assistant and/or medical supply companies.**



We are located across McMullen Booth Rd. slightly North of Mease Countryside Hospital

SAFETY HARBOR SURGERY CENTER
3280 N. McMullen Booth Rd.
Suite 110
Clearwater, FL 33761

Patient Registration

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**

Street Address: _____

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

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

Email: _____

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

**** 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) _____

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

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

Name 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 (If Applicable)
(Short Form)

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

Black Lung	____No____Yes
Research Grant	____No____Yes
Veteran Affairs	____No____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)

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

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

AMS
ANESTHESIA MANAGEMENT SOLUTIONS

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 and 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

Safety Harbor Surgery Center
Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations, per HIPAA Regulations

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine health care operations, such as assessing quality and reviewing the competence of staff

I have been informed and acknowledge receipt of information on the facility's grievance process and the ***"Notice of Patient Privacy Practices"*** and "***Patient Rights and Responsibilities***" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the ***"Notice"*** prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.
- In accordance with Medicare's Conditions of Coverage for Ambulatory Surgical Centers, the following information has been provided to you, verbally and in writing, at least 24 hours prior to your date of procedure at Safety Harbor Surgery Center.

ADVANCE DIRECTIVES and CONSENT TO TRANSFER in the event of an emergency:

Please check "I do" **or** "do not" for both items below. Please do not leave blank

I DO ____, DO NOT ____ have an Advance Directive, Living Will or Health Care Power of Attorney.

I DO ____, DO NOT ____ want to have information on Advance Directives. I may visit the State of Florida web site for Florida Advance Directive information.

It is our policy, as a matter of conscience and as permitted by state law, regardless of the contents of any advance directive or instructions from a health care surrogate or attorney in fact, that if an adverse event or unexpected deterioration occurs during your treatment at this facility we will initiate resuscitative or other stabilizing measures and transfer you 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 your wishes, advance directive or health care power of attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current health care directive or health care power of attorney. I may receive a copy of Advance Directive information upon admission to the center, if desired.

PLEASE PRINT
Restrictions:
I request the following restrictions to the use or disclosure of my health information:

_____

Please indicate below (by name and relationship), the persons with whom we may discuss your protected health information:

_____

Messages or appointment reminders:
May leave a message at your home using your doctor's/practice name: ☐ Yes ☐ No
May leave a message at your work using your doctor's/practice name: ☐ Yes ☐ No
Messages will be of non-sensitive nature, such as, appointment reminders.

I understand that as part of treatment, payment, or health care operations, it may become necessary to disclose health information to another entity, i.e., referrals to other health care providers. I consent to such disclosure for these uses as permitted by law.
I fully understand and accept/decline (please circle one) the information in this consent.

_____ _____
Patient/Guardian Signature **Date**

_____
Printed Name of Signer

If other than the patient, _____ signing, because I am the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment, or health care operations.

☐ **Consent form signature refused by patient**
☐ **Patient unable to sign consent form, reason**: _____

SAFETY HARBOR SURGERY CENTER 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	**Mease Dunedin Hospital**	**Morton Plant Hospital**
3231 McMullen Booth Road	**601 Main Street**	**300 Pinellas Street**
Safety Harbor, Florida 34695	**Dunedin, Florida 34698**	**Clearwater, Florida 33756**
(727) 725-6111	**(727) 733-1111**	**(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 OF Safety Harbor Surgery Center. Owners include:** Dr. Umesh Choudhry; Dr. Dana Deupree; Dr. Theodore Small; Dr. Satinderpal Sondhi; Dr. Michael Manning; Dr. Robert Roth; Dr. Aaron Davis; Dr. Lee Ann Brown; Dr. Priya Vakharia; 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: _____

PATIENT'S STATEMENT OF RIGHTS AND RESPONSIBILITIES

The staff of this health care facility recognizes you have rights while a patient receiving medical care. In return, there are responsibilities for certain behavior on your part as the patient. This statement of rights and responsibilities is posted in our facility in at least one location that is used by all patients.

Your rights and responsibilities include:
A patient, patient representative or surrogate has the right to

- Receive information about rights, patient conduct and responsibilities in a language and manner the patient, patient representative or surrogate can understand.
- Be treated with respect, consideration and dignity.
- Be provided appropriate personal privacy.
- Have disclosures and records treated confidentially and be given the opportunity to approve or refuse record release except when release is required by law.
- Be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- Receive care in a safe setting and be free from all forms of abuse, neglect or harassment.
- Exercise his or her rights without being subject to discrimination or reprisal with impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical disability, or source of payment.
- Voice complaints and grievances, without reprisal.
- Be provided, to the degree known, complete information concerning diagnosis, evaluation, treatment and know who is providing services and who is responsible for the care. When the patient's medical condition makes it inadvisable or impossible, the information is provided to a person designated by the patient or to a legally authorized person.
- Exercise of rights and respect for property and persons, including the right to
  - o Voice grievances regarding treatment or care that is (or fails to be) furnished.
  - o Be fully informed about a treatment or procedure and the expected outcome before it is performed.
  - o Have a person appointed under State law to act on the patient's behalf if the patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction. If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.
- Refuse treatment to extent permitted by law and be informed of medical consequences of this action.
- Know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.
- Have the right to change providers if other qualified providers are available.
- A prompt and reasonable response to questions and requests.
- Know what patient support services are available, including availability of an interpreter if patient does not speak English.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care and know, upon request and prior to treatment, whether the facility accepts the Medicare assignment rate.
- Receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- Formulate advance directives and to appoint a surrogate to make health care decisions on his/her behalf to the extent permitted by law and provide a copy to the facility for placement in his/her medical record.
- Know the facility policy on advance directives.
- Be informed of the names of physicians who have ownership in the facility.
- Have properly credentialed and qualified healthcare professionals providing patient care.
- A patient receiving care in a health care facility has the right to bring any person of his or her choosing to the patient accessible areas of the healthcare facility to accompany the patient while the patient is receiving 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 cannot be reasonably accommodated by the facility.

A patient, patient representative or surrogate is responsible for

- Providing a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, unless specifically exempted from this responsibility by his/her provider.
- Providing to the best of his or her knowledge, accurate and complete information about his/her health, present complaints, past illnesses, hospitalizations, any medications, including over-the-counter products and dietary supplements, any allergies or sensitivities, and other matters relating to his or her health.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Following the treatment plan recommended by his health care provider.
- Be respectful of all the health providers and staff, as well as other patients.
- Providing a copy of information that you desire us to know about a durable power of attorney, health care surrogate, or other advance directive.
- His/her actions if he/she refuses treatment or does not follow the health care provider's instructions.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to his health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- Keeping appointments.

COMPLAINTS

We want to provide you with excellent service, including answering your questions and responding to your concerns. You can ask any of our staff to help you contact the Administrative Director at the surgery center.

You may also choose to contact the licensing agency of the state. To report a complaint regarding the services you received, please call the Agency for Health Care Administration toll-free (1-888-419-3456)

Agency for Health Care Administration
2727 Mahan Drive, Tallahassee, FL 32308

If you are covered by Medicare, you may choose to contact the Medicare Ombudsman at 1-800-MEDICARE (1-800-633-4227) or online at https://www.cms.gov/center/special-topic/ombudsman/medicare-beneficiary-ombudsmanhome

The role of the Medicare Beneficiary Ombudsman is to ensure that Medicare beneficiaries receive the information and help you need to understand your Medicare options and to apply your Medicare rights and protections.

Medicaid Fraud
To report suspected Medicaid fraud, please call AHCA Medicaid Program Integrity toll-free at (1-888-419-3456) or the Attorney General toll-free at (1-866-966-7226)

Abusive, Neglectful, or Exploitative Practices
To report abuse, neglect, or exploitation, please call the Florida Department of Children and Families toll-free (1-800-962-2873)

Safety Harbor Surgery Center

United Surgical Partners International

NOTICE OF PRIVACY PRACTICES

United Surgical Partners INTERNATIONAL

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. You 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 use 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