



Dear Patient:

Thank you for choosing Tampa Outpatient Surgical Facility.

Enclosed, you will find the necessary documentation to be completed and returned to the Surgical Center on the day of your scheduled procedure. Please ensure that you have read all the documents carefully, and complete them to the best of your ability.

Within 1-2 days our pre-operative nurse will contact you to verify your information, health history, and provide you with the necessary pre-operative instructions including estimated time of arrival. In addition, you may also receive a call from our Business Office regarding your insurance coverage and applicable payment.

Important

- If your demographic or insurance information has changed since your scheduled procedure, update the facility at your earliest convenience.
- Bring all the necessary documentations on the day of your surgery:
 - Insurance card (if applicable)
 - Photo ID - *A photo ID is required of all patients who are over the age of 18. If patient is a minor, all parents or legal guardians must provide a photo ID and legal documentation of guardianship if minor is not your biological child.*
- Please do not bring valuables, including, but not limited to, jewelry, dentures, purse, etc.

If you have any questions, please do not hesitate to contact us at 813-875-0562. We would be happy to answer any questions you may have. You may also visit us on the web at www.tampaoutpatient.com.

Sincerely,

All of us at TOS

Mission and Vision Statement

At Tampa Outpatient Surgical Facility our mission is to provide our patients with the highest quality outpatient surgical facility and the highest quality staff. Our staff delivers superior medical care to our patients in an efficient, cost-effective, compassionate, dignified and safe environment in order to achieve the best clinical outcomes while maintaining sensitivity to pain control and privacy.

IMPORTANT PRE-OPERATIVE INSTRUCTIONS

The following are guidelines that must be followed prior to your surgery:

- No food or drink after midnight unless directed by your physician
- Patients may have a “sip” of water only with medications the morning of the surgery unless stated otherwise by physician performing the surgery
- If you are currently on any blood thinners or over the counter NSAIDs such as: aspirin, ibuprofen, Motrin, Aleve, naproxen or meloxicam, please inform the nursing staff and the physician that you are taking these medications. You may be asked to stop these medications at least 7 days prior to you procedure.
- It is important to inform the surgeon if you are taking any medications such as Plavix, Warfarin, Eliquis or other blood thinners. You may be required to coordinate with your prescribing physician of your medications on when to safely discontinue these medications and resuming these medications post-surgery.
- The morning of your surgery, follow the medication instructions given to you by the preadmission nurse or physician assistant.
- If you did not speak directly with a nurse, please bring all current medications in original bottles, including all vitamins and herbal supplements.
- Wear loose and comfortable clothing. If you are having shoulder surgery, wear a button down shirt. If you are having foot or knee surgery, wear loose pants or shorts.
- Please do not bring personal items or jewelry with you the morning of surgery. We cannot be responsible for lost belongings. However, small items can be locked away. Notify a nurse if this service is needed. You may bring your insurance card.
- You will meet with an anesthesiologist in the pre-op area. It is important for you to share any concerns or questions you may have regarding anesthesia or your past experiences with anesthesia at this time.
- If a legal guardian has been appointed, the guardian must accompany the patient with the proper guardianship papers.
- If you develop a cold, sore throat, fever, or any symptoms of illness, notify your surgeon as your surgery may need to be rescheduled.
- A responsible/licensed driver must accompany you the day of surgery and leave contact information to notify them when you are ready for discharge.
- You must have someone home with you for 24 hours upon discharge.

Your cooperation in following these instructions is essential to ensure a safe surgical experience.

Failure to comply with these instructions may result in the cancellation of your surgery.

Patient's Rights and Responsibilities:

In recognition of our responsibility in rendering patient care, these rights and responsibilities are affirmed in the policies and procedures of the facility

The Patient has the right to:

- To be treated with courtesy & respect
- To prompt & reasonable response to questions & request
- To know who is providing medical services & who is responsible for his or her care
- To know what patient support services are available, including whether an interpreter is available, if he or she does not speak English
- To know what rules & regulation apply to his or her conduct
- To be given information concerning diagnosis, planned course of treatment, alternatives, risk, prognosis by the healthcare provider
- To refuse treatment, except as otherwise provided by law
- To be given, upon request, full information & necessary counselling on the availability of knowing financial resources for his or her care
- To know upon request, full information & necessary counseling on the availability of knowing financial resources for his or her care
- To know upon request & in advance treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate
- To receive upon request, prior treatment, a reasonable estimate of charges for medical care
- To receive a copy of reasonable clear & understandable, itemized bill &, upon request, to have charges explained
- To receive impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment
- To receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- To know if medical treatment is for purposes of experimental/research & to give his or her consent or refusal to participate in such experimental research
- To express grievances regarding any violation of their rights, as stated in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served them, & to the appropriate state-licensing agency
- To participate in decisions involving their healthcare, unless contraindicated by concerns for their health

A Patient is responsible:

- To provide accurate and complete information concerning his/her health status, medical history, hospitalizations, medications and other matters related to his/her health
- To report perceived risks in his/her care and unexpected changes in his/her condition to the responsible practitioner
- To report comprehension of a contemplated course of action and what is expected of the patient, and to ask questions when there is a lack of understanding
- To follow the plan of care established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders
- To keep appointments or notifying the facility or physician when he/she is unable to do so
- To be responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders

- To assure that the financial obligations of his/her healthcare care are fulfilled as promptly as possible
- To follow facility policies, procedures, rules and regulations
- To be considerate of the rights of other patients and facility personnel
- To be respectful of his/her personal property and that of other persons in the facility

Please contact us if you have a question or concern about your rights or responsibilities. You can ask any of our staff to help you contact the Administrative Director at the surgery center. Or, you can call (813) 875-0562.

We want to provide you with excellent service, including answering your questions and responding to your concerns.

You may also choose to contact the licensing agency of the state,
Agency for Health Care Administration
2727 Mahan Drive, Tallahassee, FL 32308
1-888-419-3456

If you are covered by Medicare, you may choose to contact the Medicare Ombudsman at 1-800-MEDICARE (1-800-633-4227) or on line at <http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html>. 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.

Notice of Privacy:

This notice describes how medical information about your information or your child may be used and disclosed and how you can access this information. Please read carefully. The following is the privacy policy of Tampa Outpatient Surgical Facility as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there, commonly known as HIPAA. HIPAA requires Tampa Outpatient Surgical Facility by law, to maintain the privacy policy with respect to you or your child health information. We are required by law to abide by the terms of this Privacy Notice.

Treatment - Your **health information** may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment - Your **health information** may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated

Healthcare Operations - Your health information may be used as necessary to support the day-to-day activities and management of Tampa Outpatient Surgical Facility. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement - Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting

Public Health Reporting

Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable disease to the state's public health department

Additional Uses of Information

Appointment Reminders -Your health information will be used by our staff to send you or contact you about appointment reminders.

Information about Treatments - Your health information may be used to send you information on the treatment and management of you medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you

Individual Rights - You have certain rights under the federal privacy standards.

You have the right to:

- Request restriction on the use and disclosure of your protected health information.
- Receive confidential communications concerning you medical condition and treatment.
- Inspect and copy you protected health information.
- Amend or submit corrections to you protected health information.
- Receive an accounting of how & to whom you protected health information has been disclosed.
- Receive a printed copy of this notice.

Tampa Outpatient Surgical Facility Duties

- Maintain the privacy of your protected health information & to provide you with this notice of privacy practices.
- Abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices - As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information - As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Admitting and Registration Clerk or Facility Privacy Officer.

Internet Privacy Notice - Whenever you visit a website, certain information is also sent to that site by your browser. Types of information that can be gathered include the kind of operating system you're using, your browser type and browser version, your screen resolution and color depth, and whether you reached the site from a search engine. Personal information, including your email address, is not available when you visit a website, unless you voluntarily submit it.

Of the information we learn about you from your visit to the Tampa Outpatient Surgical Facility website, we store the type of browser you are using, the color depth and resolution of your system, and if you came to us from a search engine. This information is used exclusively to better the performance of this website and better its ability to assist users in finding the information they need.

If you send email to the **Tampa Outpatient Surgical Facility (TOSF)**, we use your return email address only to reply to your email. We do not give, share, sell or transfer any personal information, including email addresses, to a third party.

Complaints - If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

**Privacy Officer
Tampa Outpatient Surgical Facility (TOSF)
5013 North Armenia Avenue
Tampa, FL33603**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

**Administrator
Tampa Outpatient Surgical Facility (TOSF)
5013 North Armenia Avenue
Tampa, FL33603
813.875.0562**

Financial Policy

Prior to your procedure, you will be contacted regarding your insurance coverage. If you have not been contacted before your procedure, please call us at (813) 875-0562. You may also want to contact your insurance company if you have a question regarding coverage.

The day of procedure, your co-pay, deductible, or self-pay payment is due. Unless other arrangements have been made, payment is expected at the time of service. All payment plans are administered through ePay Services.

After your procedure, we will file your insurance claim, if applicable. We will send you a statement that will include the facility fee for use of the Surgery Center. If facility costs are more than anticipated from your insurance carrier, you will be billed for the difference.

Payments are due within 30-days of your mailed invoice. If payment is not made, you will receive additional notification and after 90-days, may be sent to collections. Any overpayments will be refunded to you.

If you would like a price quote, please formally request one from your physician so that the correct procedure is accurately quoted. Workers' Compensation Claims require more information. We will send you the quoted price within 10-business days.

Workman Compensation:

If your surgery is the result of an accident at work, we may need specific information (i.e., Workers' Compensation Carrier, agent or person to contact at work, employer's address, date and time of your accident, and/or claim number) from you prior to surgery.

Surgeon, Anesthesia and Pathology Billing:

Your surgeon, anesthesiologist, and pathologist will bill you separately. Questions about these bills should be addressed to the respective party.

Forms of Payment:

We accept: Cash, Visa, American Express, MasterCard, Discover Card, Debit/ Credit Cards including Health Credit Cards such as Care Credit.

Participating Insurance Programs

We accept most insurance plans. If you are unsure about your coverage or our participation in your plan, please contact us at (813)875-0562 with your questions.



TOSF REGISTRATION FORM

PATIENT INFORMATION:

NAME: _____ **DATE:** _____
Last First MI
SOCIAL SECURITY #: _____ **DATE OF BIRTH:** ____/____/____ **GENDER:** M F
HOME PHONE: (____) _____ **CELL PHONE:** (____) _____ **MARITAL STATUS:** S M D W
MAILING ADDRESS: _____
Street Address Apt # City State Zip
RACE: American Indian Asian/Pacific Black White Hispanic Other: _____ **Email:** _____
EMPLOYED BY: _____ **PHONE:** (____) _____
PRIMARY PHYSICIAN NAME: _____ **PHONE:** (____) _____

EMERGENCY CONTACT INFORMATION:

<small>PERSON TO CONTACT IN CASE OF EMERGENCY</small>	<small>PHONE</small>	<small>RELATIONSHIP</small>

INSURANCE INFORMATION: Complete & submit your insurance card FOR us to bill your health insurance:

Relationship to Insured: (Please Circle) SELF SPOUSE DEPENDENT OTHER
Primary Insurance Co. _____ **Policy Holder (Insured):** _____
Policy #/ Member ID# _____ **Group #:** _____
Secondary Insurance Co. _____ **Policy Holder (Insured):** _____
Policy #/ Member ID# _____ **Group #:** _____

RESPONSIBLE PARTY FOR INSURANCE: MUST BE FILLED OUT IF PATIENT IS NOT THE POLICY HOLDER

NAME: _____ **PHONE NUMBER:** (____) _____
SOCIAL SECURITY #: _____ **DATE OF BIRTH:** ____/____/____
PLACE OF EMPLOYMENT: _____ **PHONE:** (____) _____
 Is this a **Workman's Compensation** case? Yes No **Date of Incident:** ____/____/____
 Is this an **Auto Accident** case? Yes No **Date of Incident:** ____/____/____
Adjuster's Name and Phone Number: _____
 Is this due to **Other Injury / Accident?** Yes No **Date of Incident:** ____/____/____

SELF-PAY CLAUSE

I understand that even though I am a self-pay patient, it is possible that components of my procedure may be covered by my health insurance. I know that if I fail to inform Tampa Outpatient of any applicable insurance in advance of my procedure, I might lose my ability to seek reimbursement from my insurance company. _____

Initial

MEDICARE SIGNATURE AUTHORIZATION:

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts the assignment. I understand that this signature is a lifetime signature.

Signature	1ST VISIT	2ND VISIT	3RD VISIT
	<small>Date/Initial</small>	<small>Date/Initial</small>	<small>Date/Initial</small>

PATIENT SIGNATURE:

The information completed on this form is true to the best of my knowledge.

Signature	1ST VISIT	2ND VISIT	3RD VISIT
	<small>Date / Initial</small>	<small>Date / Initial</small>	<small>Date / Initial</small>

Name: _____

Patient Disclosure Statement

Florida Surgery Center Enterprises, LLC D/B/A Tampa Outpatient Surgical Facility is a Limited Liability Corporation (LLC), which is owned by Nakanachi I and other practicing specialists that have a financial interest, one of which may be your physician. The other practicing specialists are Thomas Greene, MD, Willem Nel, MD, Marc Weinstein, MD, and David Halpern, MD. These parties have become owners as a result of their commitment to the highest quality healthcare and superior customer service. Tampa Outpatient Surgical Facility may have a financial relationship with your physician, as indicated. You have the right to choose an alternative source of service. Please contact your physician to obtain a list of sites he/she may have privileges to practice. A schedule of typical fees for services by facility is available at your request. **Initials: _____**

Acknowledgement of Receipt of Patient Rights and Responsibilities

I acknowledge that I received and understand the Patient's Rights and Responsibilities. **Initials: _____**

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I received Notice of Privacy Policy and understand my rights. **Initials: _____**

Acknowledgement of Receipt of Advance Directives

I acknowledge that it is the practice of Tampa Outpatient Surgical Facility to not accept Advance Directives. Information regarding advance directives will be given to me by request. I understand that if I currently have advanced directives they will be suspended for the period of time that I am treated in the center. If I require additional care in the hospital my advance directives will be in effect for that care. **YOU MUST BRING A COPY OF YOUR ADVANCE DIRECTIVE WITH YOU ON THE DAY OF YOUR PROCEDURE.** If I do not have advanced directives I have been offered information to create my own advance directive upon request. **Initials: _____**

Living Will:

I have read and understood the information provided to me by the staff regarding the Rescinding of my Will. I agree and understand that upon signing the Living Will Rescind Agreement, I am agreeing to temporarily rescind my Living Will while I am inside the Facility. I also understand that upon signing the agreement, this agreement to Rescind my Will be enforced for thirty (30) days from the date of my signature. **Initials: _____**

Financial Agreement and Assignment of Insurance Benefits.

I accept responsibility to ensure that all services are paid in full within 90 days according to the following guidelines: **Initials: _____**

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Authorization for Release of Protected Health Information

I authorize: _____ Phone _____

I do not authorize the release of PHI to anyone other than myself.

The release of my medical information to/from:

Tampa Outpatient Surgical Facility

5013 N Armenia Ave

Tampa, FL. 33647

Phone: (813) 875-0562

Fax: (813) 875-1983

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the release of information may no longer be protected by federal and state privacy regulations.

To the party receiving the information: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

Name: _____

Date: _____

Patient Signature: _____

Witness Signature: _____

Date: _____

Patient Sticker

Consent Form to Temporarily Rescind a Living Will and Permit Cardiopulmonary Resuscitation During Outpatient Surgery/Procedure

1. Have you executed a Living Will? **YES** **NO**
2. Have you executed a Durable Power of Attorney for decision-making? **YES** **NO**

I understand that my Living Will Declarations may include D.N.R. (Do Not Resuscitate) orders that are ordinarily intended to apply only to situations where the dying process cannot be reversed, and where respiratory and/or cardiac arrest are natural manifestations of imminent death.

I have also been advised that cardiac and/or respiratory depression of varying degrees commonly occurs during the routine administration of all types of sedation or anesthesia, is usually reversible, and as such, is not ordinarily a sign of impending death.

Therefore, I consent to allow full life support measures to be provided for me, as needed, while I am a patient at Tampa Outpatient Surgical Facility. I do so with the understanding that if prolonged life support measures become necessary for any reason, they will only be continued until I can be safely transferred to the nearest hospital. At that time, those measures could be discontinued, in accordance with my Living Will, if there indeed were no reasonable expectation for my recovery.

Name: _____

Date: _____

Patient Signature: _____

Witness Signature: _____

Date: _____

PLACE PATIENT STICKER HERE

TeamHealth, Gulf-To-Bay Anesthesiology Associates

Base Pointe Anesthesia Billing Center

3231 North Star Circle, Louisville, TN 37777, (877) 307-4554

Release of Medical Information and Payment Agreements

TeamHealth Gulf-To-Bay Anesthesiology is a professional association, which provides anesthesia services as an independent contractor for Tampa Outpatient Surgical Facility. Your anesthesia bill will be separate from the surgery center's bill and from your surgeon's bill. If you have any questions regarding our participation with your insurance company or any other billing questions, please contact us at the above phone number.

I authorize TeamHealth Gulf-To-Bay Anesthesiology to release my medical records and other medical information as may be necessary to any person or corporation which may be liable for all or part of the charges for my medical care, including but not limited to my insurance company or companies, Medicare, Medicaid, worker's compensation carriers, or my employer. The release of such information shall be for the purpose of reimbursing TeamHealth Gulf-To-Bay Anesthesiology Associates for the medical services rendered to me. The information to be released may include any medical records relating to treatment or diagnosis of alcohol or drug-related illnesses, psychiatric or other mental care, eating disorders, or human immunodeficiency virus/AIDS test results.

I assign to TeamHealth Gulf-To-Bay Anesthesiology my right to receive payment for any medical treatment provided to me by TeamHealth Gulf-To-Bay Anesthesiology. I agree to make full payment for medical treatment provided by TeamHealth Gulf-To-Bay Anesthesiology within 60 days and agree to pay all charges not covered by insurance or other payor, except as prohibited by law.

I understand that TeamHealth Gulf-To-Bay Anesthesiology may bill and charge for services provided by my anesthesiologist and other members of the anesthesia care team. I hereby authorize payment directly to TeamHealth Gulf-To-Bay Anesthesiology of benefits otherwise payable to me or my anesthesiologist and anesthesia care team members.

For self-pay patients:

I understand that any money paid prior to surgery is only an estimate. The estimate is based on the estimated length of the surgery. The exact charges cannot be determined in advance. If your surgery goes over the estimated length, you will be billed for the balance. If your surgery is under the estimated length, you will be issued a refund.

The consent is subject to revocation at any time except to the extent that TeamHealth Gulf-To-Bay Anesthesiology has already taken action in reliance upon it. If not previously revoked, this consent will terminate when all payment transactions regarding my treatment have been completed.

If this form is signed by a Responsible party, the Responsible party attests that he or she is authorized to agree to the terms of this form on behalf of the patient, and so agrees, and the Responsible party accepts responsibility for payment of the patient's medical bills.

Signature of Patient or Responsible Party

Date

Relationship of Responsible Party to patient _____



Name: _____

Additional Information for Today's Procedure

Driver Information:

This person will be driving me home after discharge: _____

- Driver will remain at the center during surgical procedure.
- Driver will be leaving the facility during the procedure & can be reached at:

If your driver is called back to the facility to pick you up, please have them park at the side of the facility in the designated "Patient Pickup" parking spot. They should ring the doorbell at the double doors under the orange canopy. Our staff will take them to you for discharge.