

PHOTO ID REQUIRED AT CHECK-IN



Dear Parents / Guardian,

Enclosed you will find the necessary documentation that needs to be completed and brought to Pediatric Surgery Centers the day of your child's scheduled surgery. Please read these documents carefully and fill them out to the best of your knowledge. Also, please sign the bottom of all pages as noted.

A nurse from the facility will be contacting you prior to the day of surgery. They will be giving you pre-operative instruction and telling you the scheduled time of your child's surgery.

IMPORTANT:

- ☀ *If you did not give an available phone number where you can be reached prior to surgery, please call pediatric Surgery Centers at 813-343-5690 to update your telephone information.*
- ☀ *If you are not the biological parents, please bring all necessary documentation in order for us to provide care to your child. Not having the correct documentation will result in having to reschedule the surgery.*
- ☀ *Photo ID is required from the person legally able to sign consent on the day of surgery. Any patient 18 years or older will require their own Photo ID at the time of surgery.*

On behalf of Pediatric Surgery Centers, I would like to thank you for choosing us as your healthcare provider.

If you have any questions or concerns in regards to your child's surgery, please do not hesitate to contact us. We will be happy to answer any questions that you may have.

Sincerely,

Teri Ulm, RN
Administrator
Pediatric Surgery Centers-Brandon, LLC

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Pediatric Surgery Centers

PRE-OPERATIVE GUIDELINES

The following are the guidelines for the morning of your child's surgery:

NO FOOD, MILK, or MILK PRODUCTS after midnight the night prior to surgery.

Clear liquids up until **3** hours prior to your **estimated** surgery time.

Clear liquids consist of only:

Water

Apple Juice

Gatorade – any color

Pedialyte – any flavor

Jello or Jello Jigglers (plain—no fruit pieces or whipped cream)

Ice Pops

Popsicles – no real fruit pops or fudgesicles

Italian Ice

Icee or Slurpee – no smoothies

NO ICE CREAM

Nursing infants should feed up until 6 hours prior to surgery, and continue with clear liquids up until 3 hours prior to the **estimated surgery** time.

ALL FOOD AND MILK PRODUCTS MUST STOP AT MIDNIGHT PRIOR TO SURGERY

A nurse from Pediatric Surgery Centers will notify you the day prior to your child's surgery with the specific Check-In time and the time to stop the clear liquids.

Please note: Check-In time is NOT surgical time.

PEDIATRIC SURGERY CENTERS-BRANDON,LLC PATIENT REGISTRATION

PATIENT INFORMATION

Last Name _____ First _____ MI _____

Date of Birth ___/___/___ Age _____ Sex _____ SS# _____

Address _____ Apt/Unit# _____

City _____ St _____ Zip _____ Phone _____

Race: ___ African American-Black ___ American Indian ___ Asian-Pacific Islander
___ Black Hispanic ___ Caucasian White ___ Native Alaskan ___ White Hispanic

Nationality: ___ Hispanic/Latino ___ Non-Hispanic/Latino ___ Unknown

Family Physician/Pediatrician _____ Phone # _____

LEGAL PARENT/GUARDIAN INFORMATION

Mother/Legal Guardian 1 Name _____ SS# _____ DOB _____

Address _____ Apt/Unit# _____

City _____ St _____ Zip _____ Phone _____

Driver's License # _____ Relationship to patient _____

Employer Name _____ Phone # _____

Father/Legal Guardian 2 Name _____ SS# _____ DOB _____

Address _____ Suite# _____

City _____ St _____ Zip _____ Phone _____

Driver's License # _____ Relationship to patient _____

Employer Name _____ Phone # _____

Child Lives With _____

INSURANCE INFORMATION

Insurance Company _____

Main Policy Holder _____ Relationship to Patient _____

Main Policy Holder's Date of Birth ___/___/___ Social Security Number _____

Policy/Id # _____ Group Name/Number _____

Secondary Insurance (If Applicable)

Insurance Company _____

Main Policy Holder _____ Relationship to Patient _____

Main Policy Holder's Date of Birth ___/___/___ Social Security Number _____

Policy/Id # _____ Group Name/Number _____

STATEMENT OF TRUTHFULNESS. I state that any and all of the information provided is true and correct. Further, I understand that this form may be shared between Pediatric Surgery Centers LLC and Physician practices.

Signature _____ Print Name _____ Date _____



NOTIFICATION OF OWNERSHIP

DISCLOSURE OF OWNERSHIP INTEREST

This Facility is owned by a corporation formed by physicians. These physicians have become owners as a result of their commitment to quality healthcare and service to their patients. Your physician may be an owner of this Facility. Please be advised of the following:

- * The Facility may have a financial relationship with your physician as indicated above.
- * A schedule of typical fees for services provided by the facility is available at your request.
- * You have the right to choose where to receive services, including an entity in which your physician may have a financial relationship.

Two reasonable alternative sources of services available are:

1. Name St. Joseph's Children's Hospital of Tampa Phone # 813.870.4551
Address 3001 Dr. Martin Luther King Blvd. Tampa, FL

2. Name All Children's Hospital Phone # 727.898.7451
Address 801 6th Street South, St. Petersburg, FL

I have read and understand my rights pertaining to the information provided to me in the Notification of Ownership Statement.

Print Name: _____

Signature: _____

Date: _____



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**Pediatric
Surgery
Centers**

Pediatric Surgery Centers-Brandon, LLC participates with most health insurance plans. If a patient is not a member of any of the plans that we are contracted with, we will be more than happy to discuss this with them and even consider joining their plan.

The cost of a visit depends on the services performed by the physician and the insurance coverage you have chosen for your family. As a service to our patients, we will file on their health insurance(s), we do require that payment of any deductible, co-insurance, or co-pays be made at the time the service is rendered. Unless other arrangements have been made, payment is expected at time of service. Please contact your insurance company regarding your specific healthcare benefits.

Due to legalities with contracted plans that our office participates with, we are unable to accept only the amount the patient's insurance company pays. When participating with a contracted plan, we are legally required to collect any remaining balance. This includes deductibles, co-insurance, or co-pays. If a patient has no insurance, or does not provide us with verification (i.e. Insurance Cards) of insurance, they are considered to be a self-pay patient. Patients without insurance will be expected to pay for all charges in full prior to surgery.

We feel our fees are appropriate and fair. However, if you have any questions regarding them or a statement you have received, please give us a call.

We Accept: Cash, Check, Visa, Mastercard, Discover Card, and Debit Card

Collection Policy

As with any business, we adhere to a collection policy that ensures that we have the financial means to maintain this healthcare facility for our patients. Therefore, if a patient account becomes past due, we will take action to recover the amount due. After 90 days have passed from the balance becoming the patient's responsibility the account will be sent to a collections agency.

Not all insurance will pay 100% of our charges. The patient (and/or spouse/guarantor) is responsible to pay all sums unpaid by insurance. If it becomes necessary to collect any sum through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not. All past due balances will accrue interest at the rate of 18% per annum. The patient authorizes the release of any information acquired in the course of treatment as necessary to file insurance claims.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance company benefits be paid directly to Pediatric Surgery Centers-Brandon, LLC.

I authorize Pediatric Surgery Centers-Brandon, LLC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date: _____

Signature of Insured or Authorized Person _____

Print Name _____



Pediatric Surgery Centers Mission Statement

The mission of the Pediatric Surgery Centers is to create an optimal environment for the physical, social, and psychological well-being of the pediatric surgical patient and family. Our mission is accomplished by providing personalized attention to each patient and family by maintaining a well-trained, professional and caring staff. Pediatric Surgery Centers is responsive to the needs of the community by lowering the cost of providing quality healthcare, and to generate medically effective and cost-effective solutions for patients, physicians, payers and employees.

Patients 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 patient has the right:

- To be treated with courtesy and respect, with appreciation of his or her individual dignity and protection of his or her need for privacy.*
- To prompt and reasonable response to questions and requests.*
- To know who is providing medical services and 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 and regulations apply to his or her conduct.*
- To be given information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis by the health care provider.*
- To refuse treatment, except as otherwise provided by law.*
- To be given upon request, full information and necessary counseling on the availability of known financial resources for his or her care.*
- To know upon request, and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.*
- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.*
- To receive a copy of reasonably clear and understandable itemized bill and, 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 and 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, and to the appropriate state-licensing agency.*
- To participate in decisions involving their health care, unless contraindicated by concerns for their health.*

Patients Rights and Responsibilities

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

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, illnesses, hospitalizations, medications, and other matters relating to his or her health.

For reporting unexpected changes in his or her condition to the health care provider.

For reporting to the healthcare provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

For following the treatment plan recommended by the health care provider.

For keeping appointments and when he or she is unable to do so for any reason, for notifying the health care facility.

For his or her actions if he or she refuses treatment or does not follow the healthcare provider's instructions.

For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

For following facility rules and regulations affecting patient care and conduct.

For consideration and respect of the facility staff and property.

Filing Complaints

If you have a complaint against an ambulatory surgical center, call the consumer Assistance Unit at: 1-888-419-3456 (press 1)

Or write to the address listed below:

Agency for Healthcare Administration
Consumer Assistance Unit
2727 Mahan Drive/Bldg 1
Tallahassee, FL 32306

If you have a complaint against a health care professional and want to receive a complaint form, call the Consumer Assistance Unit at: 1-888-419-3456 (press 2)

Or write to the address listed below:

Agency for Health Care Administration
Consumer Services Unit
PO Box 14000
Tallahassee, FL 32317-4000

PEDIATRIC SURGERY CENTERS-ODESSA, LLC NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The following is the privacy policy of PEDIATRIC SURGERY CENTERS LLC {PSC} as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under, commonly known as HIPAA. HIPAA requires PSC, by law, to maintain the privacy policies with respect to your child's personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Child's Personal Health Information

We collect your child's personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your child's personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain healthcare entities, including healthcare providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your child's name, address, social security number, and others, that could be used to identify your child as the individual patient who is associated with that health information.

Disclosure of Your Child's Personal Health Information

Generally, we may not use or disclose your child's personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your child's personal health information in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to use or disclose your child's personal health information.

Without Your Consent

Without your consent, we may use or disclose your child's personal health information in order to provide him/her with the services and the treatment he/she requires or requests, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law.

Examples of treatment activities include: (a) the provision, coordination, or management of healthcare and related services by healthcare providers; (b) consultation between healthcare providers relating to a patient; or (c) the referral of a patient for healthcare from one healthcare provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of healthcare operations include: (a) development of clinical guidelines; (b) contacting patient's parents/legal guardians with information about treatment alternatives or communications in connection with case management or care coordination; and (c) medical review, legal services, and auditing functions.

As Required by Law

We may use or disclose your child's personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Examples include: (a) to notify or assist in notifying the parent, legal guardian or family member or another person responsible for your child's care about his/her medical condition or in the event of an emergency or death; (b) to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure; (c) to judicial and administrative proceedings in the course of any legal proceeding; (d) to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes; (e) to coroners or medical examiners; (f) to researchers conducting research that has been approved by an Institutional Review Board; (g) to avert a serious threat to health or safety; and (h) to provide you with appointment reminders for your child, or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Miscellaneous Activities, Notice: In the event that PSC is sold or merged with another organization, your child's health information/record will become the property of the new owner.

Your Rights with Respect to Your Child's Personal Health Information

Under HIPAA, you have certain rights with respect to your child's personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

You have the right: (a) to request restrictions on certain uses and disclosures of your child's health information. (Please be advised, however, that PSC is not required to agree to the restriction that you requested); (b) to have your child's health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request; (c) to have the right of access in order to inspect and obtain a copy of your child's health information contained in your child's designated record, except for (1) psychotherapy notes, (2) information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding, and (3) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We will require written requests.

You have the right to: (a) request that PSC amend your child's protected health information. Please be advised, however, that PSC is not required to agree to amend your child's protected health information. If your request to amend your child's health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial; (b) to receive an accounting of disclosures of your child's protected health information made by PSC; and (c) to a paper copy of this Notice of Privacy Policy at any time upon request.

Amendments to this Privacy Policy

We reserve the right to amend this Notice of Privacy Policy at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, PSC is required by law to comply with this Notice.

PSC is required by law to maintain the privacy of your child's health information and to provide you with notice of its legal duties and privacy policies with respect to your child's health information. If you have questions or complaints about any part of this notice, or if you want more information about your privacy rights, please contact the Administrator of PSC by calling this office at (813) 490-6100. If he/she is not available, you may make an appointment for a personal conference in person or by telephone within two (2) working days.

Complaints

Complaints about your privacy rights, or how PSC has handled your child's health information should be directed to the Administrator at (813) 343-5690. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509 F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide PSC with my authorization and consent to use and disclose my child's protected healthcare information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

Patient's Name (please print)

Parent/Legal Guardian Name (please print) Date

Parent/Legal Guardian Signature Date

Authorized Facility Signature Date