



Dear Parents / Guardian,

Enclosed you will find the necessary documentation that need 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.

A nurse from the facility will be contacting you the day prior to 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 that you can be reached the day prior to surgery, please call pediatric Surgery Centers at 813.490.6100 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.***

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, LLC

## **\*\*\*\*BILLING INFORMATION\*\*\*\***

There are four (4) separate entities involved in your child's surgery therefore you will receive up to four (4) separate bills and four (4) separate telephone calls for this surgery.

Each entity has separate insurance, co-payment and deductible payment/billing requirements.

The four separate entities:

- There is a separate charge from the doctor who performs your child's surgery.
- There is a separate charge from the Ambulatory Surgery Center where the surgery will take place. This is their facility fee.
- There is a separate charge from the doctor who administers the anesthesia.
- There is a separate charge from the pathology or laboratory center; if this service is performed the day of surgery.

As a courtesy, each entity will submit their separate charge(s) to your insurance carrier.

Thank you so much

# PEDIATRIC SURGERY CENTERS LLC (PSC)

## INSURANCE/FINANCIAL INFORMATION FOR SURGICAL PROCEDURES

Prior to your child's surgery, our Pre-Certification Specialist will be in contact with your Surgeons office. Benefits will be verified and prior authorization will be obtained (if required).

If authorization is required, the authorization number will be relayed to your physician's office prior to your arrival.

We will bill your Insurance Company as a courtesy to you therefore; According to your Insurance Company "Confirmation of benefits and/or authorization is not a guarantee of payment." Your carrier reserves the right to review and process the claim before they issue a guarantee of payment.

Your Insurance Policy is a contract between you and your Insurance Carrier. We will not become involved in disputes between you and your Insurance Carrier regarding pre-existing condition/clauses, deductibles, co-payments, non-covered charges or usual and customary fees.

If we are advised by your carrier of the fact that your calendar year deductible, co-payment, co-insurance etc. amounts have not been met we will contact you regarding our payment requirements prior to surgery.

Questions? Concerns? We welcome you to call our Pre-Certification Specialist at (813) 490-6100.



Pediatric Surgery Centers, 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 to discuss this with them and even consider joining their plan.

**The cost of a visit depends on the services performed by the physician. Unless other arrangements have been made, payment is expected at time of service. As a service to our patients, we will file on their health insurance(s), we do ask that payment of any deductible, co-insurance, or co-pays be made at the time the service is rendered.**

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 bill patients for 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, LLC.**

**I authorize Pediatric Surgery Centers, 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** \_\_\_\_\_



## 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

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, LLC**  
**Patient Consent: Messages and/or Appointment Reminders**  
**Per HIPAA Regulations**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(please print)

Parent/Legal Guardian Name: \_\_\_\_\_  
(please print)

Parent/Legal Guardian Signature: \_\_\_\_\_

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May we leave the following types of messages at your home, work, cell phone or emergency number:

- |  |                |
|--|----------------|
| 1. Office appointment changes/reminders.   | YES ( ) NO ( ) |
| 2. Lab and/or outpatient test results.   | YES ( ) NO ( ) |
| 3. Payment requirements for upcoming appointment.  | YES ( ) NO ( ) |
| 4. Lab/x-ray, or outpatient test appointment information.  | YES ( ) NO ( ) |
| 5. When authorization, medical records or physician script is required for upcoming patient appointment. | YES ( ) NO ( ) |
| 6. Prescription refill information.  | YES ( ) NO ( ) |

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Acknowledgement of Receipt of Notice

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of PSC'S, "Notice of Privacy Policy". I have read the Privacy Policy 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 described in the Privacy Policy.

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(please print)

Parent/Legal Guardian Name: \_\_\_\_\_  
(please print)

Parent/Legal Guardian Signature: \_\_\_\_\_

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Authorized Facility Signature  
12/04

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Today's Date

## **PEDIATRIC SURGERY CENTERS 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) 490-6100. 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

**PEDIATRIC SURGERY CENTERS LLC PATIENT REGISTRATION**

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Sex \_\_\_ SS# \_\_\_\_\_  
Other Name (Nickname/AKA/Maiden) \_\_\_\_\_  
Address \_\_\_\_\_ Apt/Unit# \_\_\_\_\_  
City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
Race: \_\_\_ African American-Black \_\_\_ American Indian \_\_\_ Asian-Pacific Islander  
      \_\_\_ Black Hispanic \_\_\_ Caucasian White \_\_\_ Native Alaskan \_\_\_ White Hispanic  
School \_\_\_\_\_ School Phone # \_\_\_\_\_  
Family Physician/Pediatrician \_\_\_\_\_ Phone # \_\_\_\_\_

**EMERGENCY NOTIFICATION \*Person to Notify (Other than parent)\***

Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_  
Work Phone # \_\_\_\_\_ Relationship To Patient \_\_\_\_\_

**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 \_\_\_\_\_



# **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 scheduled surgery time.

Clear liquids consist of only:

- Water
- Apple Juice
- Gatorade
- Pedialyte
- Jello (plain – no fruit pieces)
- Ice Pops

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

**A nurse from Pediatric Surgery Centers will notify you the day prior to your child's surgery with the scheduled time of surgery and specific instructions.**



## **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 requires a commitment to quality safety and education from the facility's medical staff and employees. 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 knowing financial resources for his or her care.**
- To know upon request and in advance treatment, whether the health care provider or health care 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 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 or 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 health care 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, past 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 health care 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**