Peace River
Surgery Center
4130 Tamiami Trail, Ste. 301
Port Charlotte, FL 33952

Patient Notification and Acknowledgement

Safe Discharge Policy

I understand that when I am discharged post-procedure, I am required to have an adult 18 years or older transport me home and remain with me for 24 hours as stated by Accredited Federal and State safety regulations which the center is associated with and complies with.

I understand that it is my responsibility to arrange these accommodations and that I will inform the physician or staff if I am unable to meet these expectations. Should I fail to notify the physician and staff, I am assuming all risk in the event an incident occurs upon discharge and I acknowledge that the facility is not held liable for such an incident.

I understand that the facility has the authority to inform the police if they notice that a patient has gotten behind the wheel of a vehicle post procedure.

Patient Initials:_____

Release of Information

I hereby authorize the Center or any physician(s) who have attended to me, to furnish my insurance company or companies, Preferred Provider Organization (PPO), or any other receiving health care facility designated or their representative with any and all medical information (including psychiatric, alcohol and drug abuse, and HIV information) that may be contained in my medical records. I also understand this authorization is valid only for the surgical procedure shown and that I may revoke this consent in writing at any time. A copy of this consent shall be considered as effective and valid as the original.

Below, I have listed the names of individuals I have authorized to have access to my personal health information.

Individual #1 Name: _____

Individual #1 Relationship: _____

Individual #2 Name: _____

Individual #2 Relationship: _____

Patient Initials:_____

Staff Privileges

Your physician approved staff privileges with HCA Florida Fawcett Hospital and ShorePoint Health Port Charlotte. That means that in the event of an emergency, you will be transferred to one of those hospitals.

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In the event of an emergency transfer, we will inform the receiving facility of your preferences in regard to blood products. In the event of an emergency:

⬜ Please report that I am willing to receive blood or blood products.

⬜ Please report that I am **NOT** willing to receive blood or blood products.

Patient Initials:_____

Policy on Advance Directives

This facility requires the following notice be signed by each patient prior to scheduled procedures to be in compliance with the Self Determination Act (PSCA) and State law and rules regarding Advance Directives. Advance Directives are a legal document that explains how and by whom you want medical decisions about you to be made if you cannot make the decisions yourself. The Advance Directives are often made and witnessed prior to serious illness or injury. There are many types of Advance Directives, but the two most common forms are:

Living Wills:

> These generally state the type of medical care an individual wants or does not want if he/she becomes unable to make his/her own decisions.

Durable Power of Attorney for Health Care:

> This is a signed, dated, and witnessed paper naming another person as an individual's agent or proxy to make medical decisions for that individual if he/she should become unable to make his/her own decisions.

In the ambulatory care setting, if a patient should suffer cardiac or respiratory arrest or other life-threatening situation, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, Peace River Surgery Center is notifying you it will **NOT HONOR** previously signed advance directives, excluding Power of Attorney, for any patient. If you disagree, please address this issue with your physician prior to signing this form.

⬜ I do not have advanced directives

- ⬜ I wish to get more information on advance directives
- ⬜ I decline to get more information on advance directives

⬜ I have advanced directives

- ⬜ I have given the facility a copy of my advanced directives

Patient Initials:_____

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Disclosure of Ownership

The Patient Self-Referral Act of 1992 requires that we notify our patients in writing that their physician(s) may have an ownership interest in this facility. Peace River Surgery Center is a physician owned company with a 50/50 ownership by Dr. David Hotchkiss and Dr. Nicolai Mejevoi. In addition to the Peace River Surgery Center, your physician has privileges at other local facilities. You, the patient, have the right to choose an alternate facility for treatment. If you have any questions concerning this disclosure, please ask to speak to the administrator of this Center.

Patient Initials:_____

Patient Privacy Notice

The following describes how medical information about you may be used and disclosed and how you may gain access to this information. Please review carefully.

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information.

This notice of privacy practices describes how we may use and disclose your protected health information to carry out treatment, payment, or healthcare operations and for other purposes that are permitted by law. It also describes your rights to access and control your protected health information.

We will use your medical information as part of rendering patient care. For example, your medical information may be used by your doctor or nurse treating you, by the business office to process your payment for services rendered, or in order to support the business activities of the practice.

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

· Appointment Reminders
· Treatment Information Disclosure to Department of Health and Human Service
· Health Oversight Activities
· Abuse or Neglect
· Legal Proceedings
· Law Enforcement
· Coroners, Medical Examiners, and Funeral Directors
· Organ Donations
· Public Safety
· Workers' Compensation
· Business Associates
· Authorizations

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You have the following rights with respect to your medical information:

- You have the right to restrict certain uses and disclosures of your medical information. When not obligated by law, we will honor this decision.
- You have the right to receive communication from us in a confidential manner.
- You may request an amendment to your medical information. Peace River Surgery Center has the right to deny your request. You will be provided a written explanation for the denial.
- You have the right to receive an accounting of the disclosures of your medical information made by our Center during the last six years, except for treatment disclosures, payment, or healthcare operations.
- You have the right to file a complaint with us and/or the United States Department of Health and Human Services if you believe that your rights have been violated. If you choose to file a complaint, you will not be retaliated against in any way. To file a formal complaint directly with us or if you would like further information regarding your rights or regarding the uses and disclosures of your medical information, please contact our Center and speak to administration at 941-421-0580.
- Your medical records may be accessed through our website by creating an account in Patient Portal . In addition, you may request to have your records through our unit secretary.

Patient Initials:_____

Statement On Video Recording

Patient bay areas will have video surveillance capability. The sole purpose of the video surveillance is to monitor our patients during the critical recovery period.

Patient Initials:_____

Patient Rights and Responsibilities

The staff of this facility recognizes you have rights as 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.

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Patient Notification and Acknowledgement

- Know what patient support services are available at the facility.
- 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 rights and respect for property and persons, including the right to voice grievances regarding treatment or care that is (or fails to be) furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- 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 the 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.
- Change primary or specialty physicians if other qualified physicians are available.
- A prompt and reasonable response to questions and requests.
- Know what patient support services are available, including whether an interpreter is available if he or she 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.

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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.

I am acknowledging that I have been provided the information regarding my rights and responsibilities as a patient and have received a copy of my rights and responsibilities upon request. I am also fully aware and understand my rights and responsibilities as a patient.

Patient Initials:_____

Financial Agreement

In an effort to control costs and provide the best possible care for our patients, we have established the following financial policy. We hope that this will answer any questions you may have in regard to your financial responsibilities.

1. All insurance co-pays and deductibles are due at the “time of service”. For your convenience, we accept Visa, MasterCard, Discover, debit card, personal checks, and cash as forms of payment at our facility. If your check is returned to us for any reason, you will be charged a $25.00 fee.

2. If your insurance company requires a referral for you to see our physicians, it is your responsibility to provide our office with a referral from your primary care physician. If your insurance company denies payment due to no referral, you, the patient, are responsible for any charges incurred during your visit.

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3. Keep in mind that your insurance coverage is an agreement between you and your insurance company. As a courtesy to our patients, we will file your initial claim for you. For Medicare patients, we will file your secondary & additional insurance as well. If payment is not received within 30 days, or a balance remains after payments are received from your insurance company, you may be billed for the balance. Insurance payments made directly to the patient for Peace River Surgery Center services rendered are due to Peace River Surgery Center immediately.

4. Not all insurance plans cover all services. If your insurance company determines a service is “not covered”, you will be responsible for the balance. Additionally, if your insurance company only covers a percentage of the service, you are responsible for the remaining portion.

5. In the event that you have a “patient due” balance on your account at the time of a visit, you will be asked to bring your account current prior to your appointment with the Doctor. If you are unable to do this, upon completion of a financial disclosure, our Financial Department will be happy to work out a “payment plan” with you.

6. For all outstanding balances, a payment plan structure may be set up as follows:

Balance Due	# of Months
Less than $100	2
$100.01-$300	3
$300.01-$500	4
$500.01-$800	6
$800.01-$1500	8
$1500.01-$2500	10
$2500.01-$4000+	12

7. Any accounts with an outstanding balance after 90 days of notice, without pending insurance and/or financial arrangements, will be sent to an outside collection agency. If this is the case, you may be required to pay for any further appointments or tests, in full, on the day of service.

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8. A patient under the age of 18 must be accompanied by a parent or legal guardian to authorize treatment and make financial arrangements. If a custodial parent is present but does not carry the patient on their personal insurance, we can submit charges to the patient's insurance provider. However, the parent presenting the child will be billed for any balance uncovered by the patient's insurance. Patients 18 and over are financially responsible for charges incurred during each visit.

9. We require notification at least 24 hours in advance if you are unable to make your scheduled procedure time. A no-show fee for Peace River Surgery Center testing is $75.00. No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

10. We will make every effort to work with you; however, reasons such as but not limited to: failure to keep appointments, non-compliance with prescribed treatment plan, abusive behavior toward staff members, and/or failure to pay your bill, may result in dismissal from the Center. If removed from Peace River Surgery Center, you are eligible for emergency treatment only. Emergency care is provided for a maximum of 30 days. After that time, you will be required to seek medical treatment from another facility.

I have read and understand Peace River Surgery Center's policy and I agree to its terms. I also understand that such terms may be amended without notice by the Peace River Surgery Center at any time.

Patient Initials:_____

Patient Grievance

We strive to make your stay with us a pleasant experience. If you are not satisfied with any part of your care, we encourage you to follow the chain of command and make your complaints known. We will do everything in our power to resolve the issue. If your immediate caretaker is unable to resolve the issue, you may ask to speak to our Director of Nursing or Administrator. In addition, you have the option of making your complaint in writing or via phone. Contacts for your physician's Practice Manager, Surgery Center Administrator, and the Director of Nursing are available below.

Adrienne Faulkner
Physician Practice Manager

Peace River
Cardiovascular Center
Phone: 941.255.1084
afaulkner@prcvcf.com

Mistie Gerard, RCIS
Surgery Center Administrator

Peace River
Surgery Center
Phone: 941-421-0580
mgerard@prcvcfl.com

Kaz Hill RN
Director of Nursing

Peace River Surgery Center
'941-421-0580
Khill@prcvcfl.com

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
Medicaid Complaints: https://ahca.myflorida.com/medicaid/complaints/

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Medicare Complaints

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:

https://www.medicare.gov/claims-appeals/how-to-file-a-complaint-grievance

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.

Patient Initials:_____

Patient Acknowledgement

My signature on this form is to acknowledge that I have received a copy of all required information above for the Center. This includes the **Safe Discharge Policy**, **Release of Information, Transfer Agreement**, **Policy on Advance Directives**, **Disclosure of Ownership, Patient Privacy Notice**, **Statement on Video Recording, Patients Rights and Responsibilities**, **Financial Agreement**, and **Patient Grievance**.

My signature confirms that I understand and agree with all statements made in this document and that my questions have been answered.

Patient or Legal Representative Signature:	Relationship to Patient:
Patient or Legal Representative Printed Name::	Date & Time:

Witness Signature:	Date & Time:

Place Patient Sticker Here