# 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 this accommodation 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 local law enforcement if they notice that a patient has gotten behind the wheel of a vehicle post procedure.

(Does not apply to loop recorder implant and explant procedures. If you are receiving a new loop recorder or having a previous one removed, please mark “N/A”.

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**:**

**Translation and Language Services**

In the event that a translator is necessary to effectively communicate throughout my stay at Peace

River Surgery Center, I will notify the facility a week in advance so that a translator or a language

service may be set up at no additional cost to myself.

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 (PDSA) 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; it is my responsibility to submit them to the facility to file in my chart.

Patient Initials**:**

# 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 owned by physicians; David Hotchkiss M.D, Nicolai Mejevoi M.D, and Melody Strattan D.O. 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**:**

# Staff Privileges

Your physician has 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.

In the event of an emergency transfer, we will inform the receiving facility of your preferences regarding 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**:**

# 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 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

**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**:**

PATIENT’S STATEMENT OF RIGHTS AND RESPONSIBILITIES

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

**A patient has the right to**

* Receive information about rights, patient conduct and responsibilities.
* 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.
* Be free from all forms of abuse, neglect or harassment.
* Exercise his or her rights without being subject to discrimination or reprisal with impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical disability, or source of payment.
* Voice complaints and grievances, without reprisal.
* Be provided, to the degree known, complete information concerning diagnosis, evaluation, treatment and know who is providing services and who is responsible for the care. When the patient’s medical condition makes it inadvisable or impossible, the information is provided to a person designated by the patient or to a legally authorized person.
* Exercise of rights and respect for property and persons, including the right to
  + 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 extent permitted by law and be informed of medical consequences of this action.
* Know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.
* Have the right to change primary or specialty physicians if other qualified physicians or 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.
* Be informed about the facilities advance directives policy which does not honor a Do Not Resuscitate (DNR) request/directive, and life saving care and transfer to a higher level of care as required by prevailing laws and regulations
* Know what patient support services or ADA devices are available, including an interpreter.
* Bring any person to the patient-accessible areas to accompany while receiving care or consulting with their health car provider, unless doing so would be a safety risk, or cannot be reasonable accommodated by the facility or provider.
* Be informed, when requested, of the names of physicians who have ownership in the facility.
* Have properly credentialed and qualified healthcare professionals providing patient care.

**A patient is responsible for**

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

COMPLAINTS

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 512-420-2303.

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 Healthcare Administration – State of Florida

P.O. Box 14000

Tallahassee, Florida 23317-4000

(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 [www.Medicare.gov/ombudsman/resources.asp](http://www.Medicare.gov/ombudsman/resources.asp) 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.

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. 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 45 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 PRCVC services rendered are due to PRCVC immediately.
3. 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.
4. 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 procedure. 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.
5. 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.
6. 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 the 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.

**Understand your rights against surprise medical bills**

The No Surprises Act protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. It also establishes an independent dispute resolution process for payment disputes between plans and providers and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider.

Starting in 2022, there are new protections that prevent surprise medical bills. If you have private health insurance, these new protections ban the most common types of surprise bills. If you’re uninsured or you decide not to use your health insurance for a service, under these protections, you can often get a good faith estimate of the cost of your care up front, before your visit. If you disagree with your bill, you may be able to dispute the charges. Here’s what you need to know about your new rights.

**What are surprise medical bills?**

Before the No Surprises Act, if you had health insurance and received care from an out-of-network provider or an out-of-network facility, even unknowingly, your health plan may not have covered the entire out-of-network cost. This could have left you with higher costs than if you got care from an in-network provider or facility. In addition to any out-of-network cost sharing you might have owed, the out-of-network provider or facility could bill you for the difference between the billed charge and the amount your health plan paid, unless banned by state law. This is called “balance billing.” An unexpected balance bill from an out-of-network provider is also called a surprise medical bill. People with Medicare and Medicaid already enjoy these protections and are not at risk for surprise billing.

**What are the new protections if I have health insurance?**

If you get health coverage through your employer, a Health Insurance Marketplace®, 1 or an individual health insurance plan you purchase directly from an insurance company, these new rules will: • Ban surprise bills for most emergency services, even if you get them out-of-network and without approval beforehand (prior authorization). • Ban out-of-network cost-sharing (like out-of-network coinsurance or copayments) for most emergency and some non-emergency services. You can’t be charged more than in-network costsharing for these services. • Ban out-of-network charges and balance bills for certain additional services (like anesthesiology or radiology) furnished by out-of-network providers as part of a patient’s visit to an in-network facility. • Require that health care providers and facilities give you an easy-to-understand notice explaining the applicable billing protections, who to contact if you have concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections (i.e., you must receive notice of and consent to being balance billed by an out-of-network provider). 1 Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

**What if I don’t have health insurance or choose to pay for care on my own without using my health insurance (also known as “self-paying”)?**

If you don’t have insurance or you self-pay for care, in most cases, these new rules make sure you can get a good faith estimate of how much your care will cost before you receive it.

**What if I’m charged more than my good faith estimate?**

For services provided in 2022, you can dispute a medical bill if your final charges are at least $400 higher than your good faith estimate and you file your dispute claim within 120 days of the date on your bill.

**What if I do not have insurance from an employer, a Marketplace, or an individual plan? Do these new protections apply to me?**

Some health insurance coverage programs already have protections against surprise medical bills. If you have coverage through Medicare, Medicaid, or TRICARE, or receive care through the Indian Health Services or Veterans Health Administration, you don’t need to worry because you’re already protected against surprise medical bills from providers and facilities that participate in these programs.

**What if my state has a surprise billing law?**

The No Surprises Act supplements state surprise billing laws; it does not supplant them. The No Surprises Act instead creates a “foor” for consumer protections against surprise bills from out-of-network providers and related higher cost-sharing responsibility for patients. So as a general matter, as long as a state’s surprise billing law provides at least the same level of consumer protections against surprise bills and higher cost-sharing as does the No Surprises Act and its implementing regulations, the state law generally will apply. For example, if your state operates its own patient-provider dispute resolution process that determines appropriate payment rates for self-pay consumers and Health and Human Services (HHS) has determined that the state’s process meets or exceeds the minimum requirements under the federal patient-provider dispute resolution process, then HHS will defer to the state process and would not accept such disputes into the Federal process. As another example, if your state has an All-Payer Model Agreement or another state law that determines payment amounts to out-of-network providers and facilities for a service, the All-Payer Model Agreement or other state law will generally determine your cost-sharing amount and the out-of-network payment rate.

**Where can I learn more? Still have questions?**

Visit CMS.gov/nosurprises or call the Help Desk at 1-800-985-3059 for more information.

Patient Initials**:**

**General Consent for Treatment, Assignment Of Benefits, And Notice Of Information**

I consent to treatment at Peace River Surgery Center as an outpatient depending on my medical needs. Treatment can include testing (for example, x-rays and pre-operative tests), routine care and procedures (for example, intravenous fluids or injections), and evaluation (for example, interviews and physical exams).  However, this general consent does not include consent for invasive procedures (for example, surgery) or consent for my participation in research.  Both of these circumstances require a separate consent process.

I understand that I may receive treatment given by employees (such as nurses and technicians) and by physicians and other professionals on the Medical Staff (my attending physician and consultants) who are not employees.

I understand that I retain no property rights to any tissue samples or bodily fluids removed from my body (specimens) as part of treatment.  I further understand that Peace River Surgery Center has no obligation to preserve these specimens; that it will retain or dispose of specimens according to its usual procedures.

I understand that I have the right to ask any questions about a proposed treatment (including the identity of any person providing or observing treatment) at any time.  Because medicine is not an exact science and the outcomes of treatment are dependent upon my medical condition, I understand that no guarantees can be made as to the outcome of my care.

**ASSIGNMENT OF BENEFITS**

I agree to assign any right I may have to receive payment from a health insurance plan or other payor(s) for services rendered at Peace River Surgery Center and the physicians caring for me during my treatment.  I understand that I am financially responsible for all balances that are not covered by my health insurance plan or payor, as appropriate, based on the terms of contracts or the law.  For example, the payment of non-covered services, deductibles and co-payments are the patient’s responsibility.  I also understand that I am financially responsible for collection costs should my account become delinquent.

**NOTICE REGARDING RELEASE OF HEALTH INFORMATION**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and as further explained in the Notice of Privacy Practices, Peace River Surgery Center may use and disclose medical information to physicians or other providers for the purposes of providing treatment, and to payors for the purposes of payment for medical treatment. I acknowledge the receipt of a copy of HIPPA Notice of Privacy Practices.

**PERSONAL VALUABLES**

I understand that Peace River Surgery Center is not responsible for lost personal belongings and valuables and that family members or friends should be asked to take home money, jewelry and clothing or I should request that these items be placed in a safe place (locker).  I also understand that I should inform the staff if I have dentures, eyeglasses, contact lenses, prosthetics or other items that I need to retain close by for personal functioning and to assure safekeeping.

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 Bandler CFO**

Peace River Surgery Center 941-629-5356 x 113

[abandler@prcvcfl.com](mailto:abandler@prcvcfl.com)

**Chris Arakas, RCIS Surgery Center Administrator**

Peace River Surgery Center 941-421-0580

x 210

[carakas@prcvcfl.com](mailto:carakas@prcvcfl.com)

**Ashley Erickson RN**

**Director of Nursing**

Peace River Surgery Center 941-421-0580 x 208

[aerickson@prcvcfl.com](mailto:aerickson@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/

# 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 online at:

[https://www](http://www.medicare.gov/claims-appeals/how-to-file-a-complaint-grievance).m[edicare.gov/claims-appeals/how-to-file-a-complaint-grievance](http://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, Translation and Language Services, Policy on Advance Directives**, **Disclosure of Ownership, Staff Privileges, Patient Privacy Notice**, **Patients’ Rights and Responsibilities**, **Financial Agreement**, **No Suprises Act,** **General Consent for Treatment, Assignment Of Benefits, Notice Of Information Release, Personal Valuables,** 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.

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Patient/Legal Representation Signature Print Name Date/Time

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Print Name Date/Time