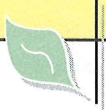

Brandon Ambulatory Surgery Center

Dear Patient:

We want to thank you for choosing our facility. This packet is designed to introduce you to our facility and our staff, and to help us gather information to help us plan the appropriate care during your visit to our center.

Instructions:

- Please read our brochures, this will answer most of your questions about our ambulatory surgery center.
- Review the "Notification To Our Patients", this form explains the following:
    - ✓ What your rights and responsibilities are as a patient
    - ✓ Explains Advanced Directives (Living Will) that should be part of your own personal healthcare plan. (If you have one please bring it with you for your medical record.)
    - ✓ Statement of disclosing if your physician is an owner in the center or not.

    This form must be dated when received.
- Please fill out the financial agreement
- Please fill out the preadmission medical history
- Please fill out the medication form

    (Just need to list medications, frequency, why you are taking it, we will do the rest)

After completed please send to the center by: ***(As soon as possible)***

- **Drop of at the center or--**
- **Fax to: 813-864-9456 or--**
- **Mail to: Brandon Ambulatory Surgery Center,**
  514 Eichenfeld Dr.
  Brandon, FL 33511

By getting this to us promptly it will save time during your preop phone call or your admission process; this gives us valuable information needed to prepare for your individualize care.

Thank you again for choosing our facility, we look forward to the privilege of taking care of you!!!

Respectfully,
Brandon Ambulatory Surgery Center Staff

Brandon Ambulatory Surgery Center
Financial Agreement

Patient Name:____________________________ Date of Surgery: _____________________
My Surgeon is: _________________________ Type of Surgery: ________________________

How can we reach you?
Cell phone: ___________________ Home Phone: _______________________________

Work Phone: ___________________ Email Address: _____________________________

Please attach the following: Patient ID Sticker

☐ **I have included a copy of my driver's license or other ID**
☐ **I have included a copy of my insurance card (front and back)**

Please initial each area:

CONSENT TO DRAW BLOOD/EMERGENCY PROCEDURES
I hereby consent to the withdrawal of a blood sample in the event an employee or contractor of the Surgery Center has a needle stick or mucous membrane exposure to my blood or body fluids. I further consent to medical treatment from a licensed physician in the event of a highly emergent or emergency event in which the patient, a family member or other responsible party cannot reasonably be reached to authorize treatment.
INITALS__________

RELEASE OF INFORMATION
In general, the Surgery Center, its personnel and members of its Medical Staff treat medical information concerning the patient's procedure as confidential. I authorize the Surgery Center to release any information necessary for the purpose of determining coverage to my insurer or other entity responsible for claims payments without my further written consent.
INITALS__________

FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS

I accept responsibility to ensure that all services are paid in full within 60 days according to the following guidelines: **Initials __________**

In consideration for the services rendered to the above-named patient, the undersigned hereby individually obligates himself/herself to the account of the Surgery Center in accordance with the Surgery Center's regular rates and terms regardless of whether insurance payments are available or made on my behalf. In the event it should be necessary to refer the account to any attorney or collection agency for collection. I hereby agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts, at the Surgery Center's option, will bear interest at the legal rate.
INITALS__________

In consideration of services rendered to the above-named patient, the undersigned hereby authorizes direct payment of any insurance benefits to the above-named Surgery Center otherwise payable to me for this admission. I transfer and assign all rights, title and interest in the above-named insurance policy any payment due me to the above-named Surgery Center. I understand and agree that I am responsible for providing any information required by my insurance company and agree to follow those pre-admission and pre-authorization guidelines, which the insurance company may require. I understand that I am financially responsible for all charges, which are not covered by insurance, including, but not limited to, co-pays, deductibles, charges in excess of policy coverage, and limitations or exclusive of coverage.
INITALS__________

PERSONAL VALUABLES AND MEDICATIONS
It is understood and agreed that the Surgery Center will not be liable for any loss or damages to valuables, including, but not limited to, money, jewelry, glasses, dentures, for items, documents, canes or personal medical equipment or supplies, clothing, shoes or other apparel. It is understood and agreed that I will not bring or consume personal medications without the Surgery Center's notice of written permission from my attending physician and that the Surgery Center will not be liable for any harm incurred thereby.
INITALS__________

HIPAA (Health Insurance and Portability and Accountability Act) (please circle YES or NO)
HIPAA policy available on request and copy located in the lobby of Brandon Ambulatory Surgery Center:

- OK to call my home: YES NO (list alternate method to contact) _________________________________)
- OK to leave a voice message:
  - With Machine: YES NO
  - With Spouse/ Significant Other: YES NO
  - With other person: YES NO (Please list) ____
- OK to discuss information regarding my procedure with (list)
  ____
- Ok to share medical information with the following: YES NO
  - Surgeon, Insurance Company, Anesthesia Providers, Laboratory Services, Radiology Services, Federal, State and Local regulatory agencies, Peer Review, committees for Performance Improvement of BASC

I understand and agree that, at the time the patient has met the Surgery Center's medical criteria to leave the center, I will have a responsible adult present to take me / patient home. I release the Surgery Center from any responsibility for events in violation of this agreement.

Name: _________________________________ will be driving the patient home after discharged from the center.

☐ **Driver will remain at the center during surgical procedure.**

☐ **Driver will be leaving the facility during the procedure and can be reached at: _______________**

I certify that I have read the foregoing and that I am either the patient, parent, legal guardian or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____________________________________ _________________________ _______________ ________AM/PM
Patient Signature Witness Signature Date Time

_____________________________________ ____
Patient Representative Relationship to Patient

Brandon Ambulatory Surgery Center

BRANDON AMBULATORY SURGERY CENTER
MEDICATION RECONCILIATION LIST

ADMISSION DATE ________________ **HT** ____________ **WT** ____________ **BMI** ______________

Allergies/Adverse drug reactions:

☐ NKAS / No Known Allergies or Sensitivities ☐ Iodine

☐ Latex / Rubber / Tape (circle one) ☐ Food

Medication Allergy/Reaction ____

____

____

List provided by: ☐ Patient ☐ Family ☐ Provided List ☐ Other ______________________

List all medications including herbal and over the counter medications

☐ NO CURRENT MEDICATION				ADMISSION MEDICATIONS		DISCHARGE MEDICATIONS	
Medication/Dose	**Frequency**	**Indication**	**Last Dose**	**Take**	**Hold**	**Resume**	**Hold**
Hx Obtained By: Signature / Date:							

New or Changed Discharge Orders

Medication	Dose	Frequency	Indication	Next Dose Due	Rx Given

Physician's Signature Date/Time Nurse's Signature Date/Time

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right 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.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- 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.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

For Complaints please address the following as appropriate:

Brandon Ambulatory Surgery Center	Florida AHCA	Centers for Medicare & Medicaid Services
Director of Nursing Deanna Pfoff, RN, LHCRM 813-571-7088	Bureau of Health Facility Regulation 2727 Mahan Drive, Mail Stop #31 Tallahassee, Florida 32308 Telephone: (850) 487-2717	Medicare Web Site www.medicare.gov Ombudsman www.cms.hhs.gov/center/ombudsman.asp 1-800-MEDICARE 1-800-633-4227

Health Care Advance Directives
The Patient's Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes).

The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.

By law hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include 58A-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

Questions About Health Care Advance Directives

What is an advance directive?

It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning. Three types of advance directives are:

- A Living Will
- A Health Care Surrogate Designation
- An Anatomical Donation

You might choose to complete one, two or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

What is a living will?

It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?

It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

Which is best?

Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

What is an anatomical donation?

It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of health care workers. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form (seen elsewhere in the pamphlet), or expressing your wish in a living will.

Am I required to have an advance directive under Florida law?

No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care or an anatomical donation may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, an adult relative, or a close friend.

The person making decisions for you may or may not be aware of your wishes. When you make an advance directive, and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?

No, the procedures are simple and do not require an attorney, though you may choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Where can I find advance directive forms?

Florida law provides a sample of each of the following forms: a living will, a health care surrogate, and an anatomical donation. Elsewhere in this pamphlet we have included sample forms as well as resources where you can find more information and other types of advance directive forms.

Can I change my mind after I write an advance directive?

Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you can also change an advance directive by oral statement; physical destruction of the advance directive; or by writing a new advance directive. If your driver's license or state identification card indicates you are an organ donor, but you no longer want this designation, contact the nearest driver's license office to cancel the donor designation and a new license or card will be issued to you.

What if I have filled out an advance directive in another state and need treatment in Florida?
An advance directive completed in another state, as described in that state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?
• If you designate a health care surrogate and an alternate surrogate be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.
• Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.
• Set up a file where you can keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.
• Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.
• If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, or the significant persons in your life.

More Information On Health Care Advance Directives
Before making a decision about advance directives you might want to consider additional options and other sources of information, including the following:

• As an alternative to a health care surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information or read Chapter 709, Florida Statutes.

If you choose someone as your durable power of attorney be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.

• If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest. The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, health care provider, or an ambulance service may also have copies available for your use. You, or your legal representative, and your physician sign the DNRO form. More information is available on the DOH website, www.doh.state.fl.us or www.MyFlorida.com (type DNRO in these website search engines) or call (850) 245-4440.

When you are admitted to a hospital the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.

• If a person chooses to donate, after death, his or her body for medical training and research the donation will be coordinated by the Anatomical Board of the State of Florida. You, or your survivors, must arrange with a local funeral home, and pay, for a preliminary embalming and transportation of the body to the Anatomical Board located in Gainesville, Florida. After being used for medical education or research, the body will ordinarily be cremated. The remains will be returned to the loved ones, if requested at the time of donation, or the Anatomical Board will spread the remains over the Gulf of Mexico. For further information contact the Anatomical Board of the State of Florida at (800) 628-2594 or www.med.ufl.edu/anatbd.

• If you would like to read more about organ and tissue donation to persons in need you can view the Agency for Health Care Administration's website http://ahca.MyFlorida.com (Click on "Site Map" then scroll down to "Organ Donors") or the federal government site www.OrganDonor.gov. If you have further questions you may want to talk with your health care provider.

• Various organizations also make advance directive forms available. One such document is "Five Wishes" that includes a living will and a health care surrogate designation. "Five Wishes" gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication, and other details that might bring you comfort such as what kind of music you might to hear, among other things. You can find out more at:
Aging with Dignity
www.AgingWithDignity.org
(888) 594-7437

Other resources include:

American Association of Retired Persons (AARP)
www.aarp.org
(Type "advance directives" in the website's search engine)

Your local hospital, nursing home, hospice, home health agency, and your attorney or health care provider may be able to assist you with forms or further information.

Brochure: End of Life Issues
www.FloridaHealthStat.com (Under Reports and Guides)

Brandon Ambulatory Surgery Center

Notification to our patients

Dear Patients:

The enclosed information is being supplied to every patient who accesses our surgery center.
We are required to provide you with the attached information both written and verbally.
Please read the following carefully and indicate with your signature that you have been provided this information on the date indicated.

1. I have reviewed and understand the patient rights and responsibilities associated with my visit to the Brandon Ambulatory Surgery Center.

2. I understand that if I currently have advanced directivves they will be suspended for the period of time that I am treated in the center. If I require additional care in the hospital my advance directives will be in effect for that care. **YOU MUST BRING A COPY OF YOUR ADVANCE DIRECTIVE WITH YOU ON THE DAY OF YOUR PROCEDURE.** If I do not have advanced directives I have been offered information to create my own advance directive.

3. I understand that my Doctor ______________________ is an owner and has a financial interest in the Surgery Center. If this is marked N/A my physician does not have an interest in the Center.

______________________	______________________
Signature of Patient	Date: (date patient received)
______________________	______________________
Signature of Responsible Party	Relationship to patient

Important Document

Please remember to bring this with you on your surgery day.
Or fax to: 813-571-7099 from the office or home

Thank you in advance for making us your provider of choice!

514 Eichenfeld Drive • Brandon, Florida 33511 • Phone: 813.571.7088 • Fax: 813.571.7099

Brandon Ambulatory Surgery Center

Before Your Surgery:
• Pre Op nurse will contact you to complete your confidential health history, this will help us to prepare for your individualized care.
• Nothing to eat or drink after midnight the day before surgery, unless otherwise instructed. (this affects your safety during your procedure.)
• Please arrange for a responsible adult to drive you home after your procedure, and make arrangements for someone to stay with you for 24 hours if appropriate.

Day of Surgery:
• Arrive promptly at the time given to you by the pre-op nurse.
• Bring surgical paper work given in the surgeons office, **including the advanced directives (living will) and your patient rights information.**
• Please shower before you arrive, this will decrease the risk of infection.
• Wear comfortable clothing, considering the type of procedure you are going to have, and you may want to bring a sweater.
All jewelry and body piercings must be removed prior to surgery. Please leave all valuables at home, but remember to bring your insurance card, identification card, copy of advanced directives if you have one, and the **NOTIFICATION TO PATIENTS** form you received in your doctors office.

• **Medications:**
• You may take your normal heart, blood pressure, breathing or seizure medication the morning of surgery with a sip of water.
• If you take insulin or routine medications we will instruct you during your pre op call.
• If you are on blood thinners, aspirin or herbal medicines, notify your surgeon when they are scheduling you for surgery.

After your surgery:
• You will be given written instructions regarding diet, activities and medications. In the event of any difficulty, call your surgeon even if after hours, there will be an answering service to assist you, or go to the nearest emergency room.
• A nurse from Brandon Ambulatory Surgery Center will call you the following day to see how you are and answer any questions you may have.

Billing:
• After surgery, we will submit your bill to your insurance company, you will note that there is separate billing for Brandon Ambulatory Surgery Center, Anesthesia and Pathology. Please contact our billing office for any questions. Deductibles and co-pays payments will be anticipated upon your arrival at the center. We accept checks, credit cards, cash, and financing is available through Care Credit.