TOMOKA SURGERY CENTER, LLC
345 CLYDE MORRIS BLVD
ORMOND BEACH, FL 32174
(386)672-7575

PLEASE READ AND INITIAL AFTER EACH PARAGRAPH

The procedure will be at Tomoka Surgery Center, LLC.
Tomoka Surgery Center is owned by four (4) partnering surgeons, each with 25% ownership.
Mark E. Kennedy, MD ● Michael K. Makowski, MD ● Timothy D. Root, MD ● Alan D. Spertus, MD

_____ **By signing this notice, you agree and understand we are disclosing this information to you as part of your patient rights that your surgeon has financial interest in this facility.**

TOMOKA SURGERY CENTER HIPAA COMMUNICATIONS FORM

I, _____ am giving Dr. _____'s office and Tomoka Surgery Center permission to communicate with me in the following ways: (Please check all that apply)

VOICEMAIL:
_____ It is OK to call my home and leave any message on my voicemail.
_____ It is OK to call my home but leave only minimal necessary information on my voicemail.
_____ It is OK to call my home but if voicemail answers, do not leave a message.

HOME:
_____ It is OK to call my home and talk with anyone who answers. If I am not available, you may tell them:
  _____ anything
  _____ only the minimum necessary
_____ It is OK to call my home and talk with only myself or _____, you may tell them:
  _____ anything
  _____ only the minimum necessary
_____ It is OK to call my home but talk only to me
_____ Do not call my home

INITIAL:_____

WHILE I AM AT TOMOKA SURGERY CENTER:
_____ TSC may give information to anyone who presents or calls about my condition while I am at the center.
_____ TSC may give information only to _____if they present or call while I am at the center.
_____ Do not give information to anyone who presents or calls about my condition while I am at the center.

INITIAL:_____

HIPAA POLICY /PRIVACY NOTICE
_____ I certify that I have received and/or reviewed a copy of the Surgery Center's HIPAA POLICY /PRIVACY NOTICE and/or document.
_____ I certify that I have received and/or reviewed a copy of the Surgery Center's PATIENT RIGHTS and/or document.

INITIAL:_____

CONSENT TO DRAW BLOOD
I hereby consent to the withdrawal of blood sample in the event an Employee or Contractor of the Surgery Center has a needle stick or mucus membrane exposure to my blood or bodily fluids. I further consent to medical treatment from a licensed Physician in the event of highly emergent or emergency event in which the patient, a family member or other responsible party cannot reasonably be reached to authorize treatment.

INITIAL:_____

RELEASE OF INFORMATION

In general, the Surgery Center, its personnel and members of its medical staff, treats 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.

INITIAL:_____

FINANCIAL AGREEMENT AND ASSIGNMENT OF MEDICAL BENEFITS

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 option will bear interest at the legal rate.

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, and charges in excess of policy coverage, and limitations or exclusive of coverage**.**

INITIAL:_____

PERSONAL VALUABLES AND MEDICATIONS

It is understood and agreed that the Surgery Center will not be liable for any loss or damages to any and all valuables, including but not limited to, money, jewelry, glasses, dentures, 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 notice of written permission from my attending physician and the Surgery Center will not be liable for any harm incurred thereby.

INITIAL:_____

ADVANCE DIRECTIVES (please *initial* each)

I understand the Surgery Center has not consented to honor an Advance Directive (Living Will) and will not be liable for its terms. Upon my request, the Surgery Center will provide information to me regarding alternative facilities that I may use.

_____ I understand I am not required to have an Advance Directive in order to receive medical treatment in this surgery center.
_____ I have not executed an Advance Directive.
_____ I understand I will be resuscitated & transferred to a hospital where my Advance Directive and/or DNR may be honored.

TO BE FILLED OUT BY OFFICE PERSONNEL ONLY:

In consideration of medical or surgical services rendered to the above-named patient, the undersigned hereby authorizes direct payment of any insurance benefits due to me to the physician named below. I transfer all rights, title, and interest in the above named insurance policy any payment due for physician medical/surgical services to:

Physician: _____ Anesthesia: Volusia Anesthesiology

I certify I have read the foregoing and I am the patient, parent, legal guardian or I am duly authorized by the patient as the patient's general agent to execute the above and accept its terms. I understand and agree that at the time the Surgery Center's medical criteria to leave the Center has been met; I will have a responsible adult present to take me/patient home. I release Tomoka Surgery Center from any responsibility for events in violation of this agreement.

_____	_____	_____	_____
PATIENT SIGNATURE	**WITNESS SIGNATURE**	**DATE**	**TIME**
_____	_____		
PATIENT REPRESENTATIVE	**RELATIONSHIP TO PATIENT**		