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 performed at Tomoka Surgery Center, LLC.

Tomoka Surgery Center is owned by five (5) partnering surgeons, each with 20% ownership.

Michael K. Makowski, MD Alan D. Spertus, MD Mark E. Kennedy, MD Timothy D. Root, MD Rory A Myer, MD

By initialing 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. INITIAL:_____

TOMOKA SURGERY CENTER HIPAA COMMUNICATIONS FORM

I, _____ am giving Tomoka Surgery Center permission to communicate with me in the following ways:

It is OK to call my home or cell phone number. YES NO
It is OK to call my home or cell phone number and leave a message on my voicemail. YES NO
It is OK to speak or leave a message with Spouse/Significant other. YES NO

List Alternative Contacts:_____
It is OK to discuss information regarding my procedure with (list):_____

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:_____

DISCHARGE AND WAIVER - if anesthesia is needed for your procedure.

- The services provided by Tomoka Surgery Center LLC are limited to those provided by the Surgeons, Nursing Staff and Surgical Tech Staff.
- The services provided by Tomoka Surgery Center LLC do not include the services provided by Volusia Anesthesia Services, or anyone employed by their group.

I discharge Tomoka Surgery Center of any and all statutory, regulatory, contractual or common law duties associated with the administration of anesthesia during the procedure to be performed. INITIAL:_____

Anesthesia Communication Notice

I expressly give my consent to Volusia Anesthesiology Associates and its employees and independent contractors may deliver to me telephone calls, telephone voice messages, telephone text messages for any purposes Volusia Anesthesiology Associates deems appropriate, by using an automated dialing system or artificial or prerecorded voice message. Such calls and messages may be delivered to me at all numbers provided by me to Volusia Anesthesiology Associates in connection with my patient account at Volusia Anesthesiology Associates. I understand I am not required to give this consent to Volusia Anesthesiology Associates as a condition of being treated or receiving services.
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

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

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. Only bring Photo ID, Insurance cards and any financial payments to be paid day of surgery.

INITIAL:_____

ADVANCE DIRECTIVES (Living Will)

Tomoka Surgery center does not honor an Advance Directive (Living Will). It is the policy of Tomoka Surgery Center, regardless of the contents of an advance directive or instructions from a healthcare surrogate or power of attorney that if an adverse event occurs during treatment, the center personnel will initiate resuscitative or other stabilizing measures, and transfer the patient to an acute care hospital for further evaluation.

_____**I DO** have a Living Will with Advanced Directives.

_____I **DO NOT** have a Living Will with Advanced Directives.

If you would like information regarding Advanced Directives and other Health Care Decisions the surgery center staff can provide you with a packet or go to www.floridahealthfinder.gov/reports-guides/advance-directives.aspx for more information.

PLEASE WAIT TO SIGN BELOW WITH TOMOKA REPRESENTATIVE

Patients and prospective patients may request from this facility and other health care providers a more personalized estimate of charges and other information. Patients and prospective patients should contact each health care practitioner who will provide services in this surgery center to determine the health insurers and health maintenance organizations with which the health care practitioner participates as a network provider or preferred provider.

Services may be provided in this health care facility by the facility as well as by other health care providers who may separately bill the patient and who may or may not participate with the same health insurers or health maintenance organizations as the facility.

The Facility fee DOES NOT include:

Physician Fees (Tomoka Eye Associates)

Anesthesiologist Fees, if one is needed for your procedure. (Volusia Anesthesia)

Other professional services you receive while you are at the surgery center, such as laboratory and pathology fees. (Mid-Florida Pathology)

You will receive separate bills for these services.

I understand and agree to have a responsible adult present to take me/patient home.

I fully understand and agree to this consent and acknowledge the above rights and disclosures.

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