Palms Wellington Surgical Center

460 State Road 7
Royal Palm Beach, Florida 33411
P: 561-792-7333 F: 561-792-6444

Patient Label

PATIENT INFORMATION / INFORMACION DEL PACIENTE

PLEASE BRING THIS COMPLETED FORM WITH YOU ON THE DAY OF SURGERY

PATIENT'S NAME HOME PHONE
Nombre del paciente _____ Telefono _____
PERMANENT ADDRESS CELL PHONE
Direccion permanente _____ Celular _____
CITY STATE ZIP CODE
Ciudad _____ Estado _____ Codigo postal _____
DATE OF BIRTH AGE MALE – Maculino ❑
Fecha de nacimiento _____ Edad _____ FEMALE – Feminine ❑
PATIENT SOCIAL SECURITY # MARITAL STATUS
Seguro social del paciente _____ Estado Civil _____
EMPLOYER (**Required** information for Workers Compensation) WORK NUMBER
Lugar de Empleo _____ Numero de trabajo _____

PRIMARY CARE PHYSICIAN/ DOCTOR PRIMARIO _____

EMERGENCY CONTACT / En caso de emergencia
NAME TELEPHONE RELATIONSHIP
Nombre _____ Telefono _____ Relacion _____

INSURANCE INFORMATION / Informacion del seguro

DATE OF FIRST SYMPTOM / FECHA DE PRIMER SINTOMA: _____

IF THIS IS RELATED TO A WORK COMP INJURY OR AUTOMOBILE ACCIDENT, PLEASE WRITE THE DATE OF INJURY: _____ ❑ Work Comp ❑ Auto ❑ Other (Indicate type of accident below)
Si esto es relacionado a un accidente fvor de escribir la fecha del accidente: _____

INSURANCE COMPANY NAME & ADDRESS: _____

CLAIM #: _____ ADJUSTER NAME: _____

POLICY #: _____ PHONE #: _____

ARE YOU BEING REPRESENTED BY AN ATTORNEY? ❑ YES ❑ NO If yes, please complete the following info:

Attorney's Name: _____ Phone #: (_____) _____

Address: _____

PRIMARY INSURANCE / SEGURO PRIMARIO
Primary Insurance Name/Address/Telephone
Nombre/Direccion/Telefono de seguro primario_____

_____

I.D. # / Numero de identificacion : _____ GROUP # / Grupo #:_____
NAME OF INSURED RELATIONSHIP DATE OF BIRTH
Nombre del asegurado _____ Relacion _____Fecha de nacimiento_____

SECONDARY INSURANCE / SEGURO SECUNDARIO
Secondary Insurance Name/Address/Telephone
Nombre/Direccion/Telefono de seguro secundario_____

_____

I.D. # / Numero de identificacion : _____ GROUP # / Grupo #:_____
NAME OF INSURED RELATIONSHIP DATE OF BIRTH
Nombre del asegurado _____ Relacion _____Fecha de nacimiento_____

EMPLOYEE USE ONLY

INITIALS _____ **DATE** _____

PATIENT CONSENT TO RESUSCITATIVE MEASURES

(NOT A REVOCATION OF ADVANCE DIRECTIVES OR MEDICAL POWER OF ATTORNEY)

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Palms Wellington Surgical Center respects and upholds these rights.

However, unlike an acute care hospital setting, Palms Wellington Surgical Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer as to its risks, your expected recovery and care after your surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. A copy of your Advance Directives or Healthcare Power of Attorney will be provided to the receiving facility so they may utilize the information contained within to make appropriate decisions in assuming responsibility for your healthcare. Your agreement with this policy by your signature below does not revoke or invalidate any current health care directive or health care Power of Attorney.

If you *do not* agree to this policy, we are pleased to assist you to reschedule the procedure.

Please check the appropriate box in answer to these questions. Have you executed an Advance Health Care Directive, a Living Will or Power of Attorney that authorizes someone to make health care decisions for you?

- ® Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney.
- ® No, I do not have an Advance Directive, Living Will or Health Care Power of Attorney.
- ® I would like to have information on Advance Directives.

If you checked the first box "YES" to the question above, please provide us with a copy of that document so that it may be a part of your medical record.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have indicated I would like additional information, I acknowledge receipt of that information.

By: _____
Patient's Signature

If consent to the procedure is provided by anyone other than the Patient, the person providing the consent or authorization must sign this form.

I acknowledge that I have read and understand its contents and agree to the policy as described.

By: _____ _____
Signature Print Name

Relationship to Patient: ® Court Appointed Guardian ® Attorney in Fact ® Health Care Surrogate

® Other_____

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POWER OF ATTORNEY, MEDICAL RELEASE and NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO A PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENTS OF BENEFITS/AUTHORIZATION TO PAY.

Known by all these present that: The undersigned has made, constituted and appointment, and by these present does hereby make, constitute and appoint Palms Wellington Surgical Center and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said Palms Wellington Surgical Center which checks, drafts or money orders are made payable for services which have been made by Palms Wellington Surgical Center at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows Palms Wellington Surgical Center or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these present does give and grant the said Palms Wellington Surgical Center as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me to release true copies of same to Palms Wellington Surgical Center or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney do or cause to be done by virtue of these present.

ASSIGNMENT OF BENEFITS

I, _____ Hereby authorize _____
To: (Name of insured) (Name of insurance carrier)

Payable and mailed directly to: Palms Wellington Surgical Center
460 N. State Road 7
Royal Palm Beach, Florida 33411

The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Palms Wellington Surgical Center any rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Palms Wellington Surgical Center.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE **NOTICE OF PRIVACY PRACTICES FOR PALMS WELLINGTON SURGICAL CENTER.**

I FULLY UNDERSTAND AND ACCEPT THE TERMS OF THIS AUTHORIZATION

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____ 201____.

_____ _____
PATIENT'S SIGNATURE PATIENT'S NAME (PLEASE PRINT)

FINANCIAL AGREEMENT

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1. In consideration of the services to be rendered to me, I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF PALMS WELLINGTON SURGICAL CENTER AND/OR IT'S ASSIGNEE'S IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF PALMS WELLINGTON SURGICAL CENTER.
   Should the account be referred to an attorney or licensed collection agency for collection, I shall pay reasonable attorney's fees and collection expenses. All delinquent accounts (those not paid within sixty (60) days from the date of service) shall bear interest at 18% per annum.

2. I hereby authorize direct payment to Palms Wellington Surgical Center of any insurance benefits otherwise payable to me for the services rendered at a rate not to exceed Palms Wellington Surgical Center regular charges. It is agreed that payment to Palms Wellington Surgical Center, pursuant of this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this agreement.

   I understand that Palms Wellington Surgical Center shall have the right at any time to refuse to provide medical care or treatment to me. I certify that I am the patient or am duly authorized by the patient as the patient's general agent to execute this document and accept its terms.

3. I understand that, as a courtesy, Palms Wellington Surgical Center will file with my primary insurance. If after sixty (60) days from the date of service and/or surgery insurance has not paid, the total balance will be considered due and payable.

THIS REFERS TO MEDICARE PATIENTS ONLY:

4. Regarding **MEDICARE ASSIGNMENT:** This means Palms Wellington Surgical Center will accept payment in full for what MEDICARE allows not what MEDICARE pays. It is the patient's responsibility for the 20% of the MEDICARE allowable for which MEDICARE does not pay. I fully understand that I agree to be responsible for this 20%

Physician Financial Ownership Palms Wellington Surgical Center is required by Federal law to notify you that all referring surgeons have financial interests or ownership in this ASC. We are required to disclose this financial interest or ownership in writing prior to the surgical procedure.

LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related MEDICARE claim. I request that the payment of authorized benefits be made on my behalf, I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to MEDICARE for payment to me.

_____ _____

PATIENT SIGNATURE DATE

Palms Wellington Surgical Center

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PATIENT LABEL

PATIENT: _____ DATE: _____

This information is required by THE AGENCY FOR HEALTH CARE ADMINISTRATION, as part of Chapter 59B9.023 of the State of Florida Statistics. The Patient's Race/Ethnicity field is used for statistical and epidemiological purposes.

Please circle one of the following:

Patient's Race-Custom Field 9:

1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or Other Pacific Islander
5. White
6. Other
7. Unknown

Patient's Ethnicity-Custom Field 11:

E1 Hispanic or Latino

E2 Non-Hispanic or Latino

E7 Unknown

Hispanic or Latino - A person of Mexican, Puerto Rican, Cuban, Central or South America or other Spanish culture or origin regardless of race

Non-Hispanic or Latino - A person not of any Spanish culture or origin

Unknown - Use if the patient refuses or fails to disclose

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, understand that Palms Wellington Surgical Center is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment or health care operations. I have read the Notice of Privacy Practices and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner of Palms Wellington Surgical Center or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this information, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (please check all that apply):

☐ **The Patient's Entire Medical Record:** This requires an explanation why the entire medical record may be disclosed.

☐ **The Patient's Demographic Information:**

☐ Name ☐ Address ☐ Telephone ☐ Date of Birth

☐ **Medical Data:**

☐ Appointment(s) Date and Time ☐ Medication(s) ☐ Lab and Test Results

☐ **Attorney authorized by this form that may use and disclose the patient's protected health information:**

Attorney's Name: _____

Address: _____

Telephone: _____ Fax Number: _____

☐ **Other Recipient(s):** _____

_____

☐ **Name(s)) of person(s) authorized by this form to which that patient's protected health information will be disclosed:**

_____

_____

☐ **Check only if applicable.** This authorization permits Palms Wellington Surgical Center to send the protected health information ONLY to this address and/or fax number:

_____

_____

Palms Wellington Surgical Center shall send information ONLY as authorized above. Any disclosure of the patient's protected health information to another person or entity not mentioned above will require a separate authorization.

_____ _____

Patient Signature **Date**