CORAL GABLES SURGERY CENTER

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Coral Gables Surgery Center creates and maintains health records describing my health history. I understand that the surgery center may use this information as:

1. A basis for planning my care and treatment;
2. A means of communication among many health professionals who contribute to my care;
3. A means by which third party payors can verify that services billed were actually provided; and
4. A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I hereby consent to the Surgery Center's use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of the surgery center. In addition, I acknowledge that I received on the date indicated below a copy of the Coral Gables Surgery Center Notice of Privacy Practices, which describes the obligations of the surgery center regarding its use and disclosure of my individually identifiable health information and my rights regarding this information. I also understand that the surgery center reserves the right to change its notice and practices. If the surgery center changes the notice, I can obtain a revised copy by asking the administrator of the surgery center. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other health care operations and that the surgery center is not required to agree to the restrictions requested. If the surgery center does agree to such restrictions, however, the surgery center must comply with such restrictions.

_____ I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

Effective Date of Notice:_____/_____/_____

_____ **Date:**_____/_____/_____

Signature of patient or patient representative

Printed name of patient or patient representative:_____

Relationship to patient:_____

Coral Gables Surgery Center

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES

I understand that advance directives are not honored at The Surgery Center of Coral Gables and that in the event of an emergency or life threatening situation, advanced cardiac life support procedures will be instituted in every instance and patients will be transferred to a higher level of care.

_____
Patient's Name

_____ _____
Patient's Signature Witness

_____ _____
Date Date

If patient is unable to sign or is a minor, please sign below:

_____ _____
Closest Relative or Legal Guardian's Signature Witness

_____ _____
Date Date

FINANCIAL AGREEMENT

If you have insurance, we will help you receive maximum benefits by filing for you. However, co-pays, co-insurance and deductibles are due at time of service., We can accept cash, credit card, money order or personal check as means of payment.
The undersigned individual guarantees prompt payment of all charges incurred. Fees related to collection of delinquent accounts will be borne by the patient.
You are responsible for any unpaid portion of your charges that your insurance or Medicare does not cover.
You will be billed separately for all services that may include facility fees, the physician's fees and pathology.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf, to the Surgery Center of Coral Gables for services rendered to me. I understand and agree to be financially responsible for charges not paid within a reasonable period of time by insurance or third party payers, and I certify that the information given with regard to insurance coverage is true and accurate to the best of my knowledge.

RELEASE OF INFORMATION

I authorize the Surgery Center of Coral Gables to release any or all of my medical records when required for the submission of any insurance claims for payment of services rendered by the Surgery Center of Coral Gables. The Surgery Center of Coral Gables, its agents, servant and employee who render services to me are herby released from any and all liability of any nature that may arise from the release of such information.

DISCLOSURE AGREEMENT

I have been informed that the physician who is rendering services may have an ownership interest in the Surgery Center of Coral Gables. I have been given the option to be treated at another facility, which I have declined. I choose to be treated at the Surgery Center of Coral Gables.

CERTIFICATE

I certify by my signature below that I have read the foregoing or the foregoing has been read to me, and that I understand completely and accept fully the terms specified therein.

PATIENT/GUARANTOR SIGNATURE _____ DATE/TIME _____
Patient Name:

Anesthesia Questionaire

The following is a list of questions that will help the Anesthesia Department evaluate your particular anesthetic needs.

Height_____

Weight_____

Recent Weight Loss_____

Cause If Known_____

		YES	NO
1.	Have you had an anesthetic before? If yes, what type?.....	____	____
	If you have had anesthesia and surgery, please list type of surgery and year _____		
2.	Did you have any side effects?.....	____	____
3.	Have any members of your immediate family had any side effects from anesthesia?	____	____
4.	Are you allergic to any medications, solutions or tapes?.....	____	____
	Please list: 1. _____ 3. _____ 2. _____ 4. _____		
5.	Are you taking any medications at the present time?.....	____	____
	Please list: 1. _____ 3. _____ 2. _____ 4. _____		
6.	Have you had any steroid (cortisone) therapy within the last year?.....	____	____
7.	Do you wear contact lenses?.....	____	____
8.	Do you wear dentures?_____ bridges?_____ or do you have loose or missing teeth?.....	____	____
9.	Have you had any problems with your lungs such as (circle)..... Tuberculosis Wheezing Asthma Cough Shortness of Breath Bronchitis Chest Pains	____	____
10.	When was the last time you had a chest x-ray?_____		
11.	Do you smoke? How many packs per day?_____.....	____	____
12.	Do you get short of breath after walking a flight of stairs?.....	____	____
13.	Do you sleep with more than one pillow?.....	____	____
14.	Have you ever had any problems with your liver, such as hepatitis?.....	____	____
15.	Have you ever had a blood transfusion? If yes, any reaction.....	____	____
16.	Do you have Diabetes or Thyroid problems?.....	____	____
17.	Have you ever had any stomach problems like: Stomach ulcers, acid reflux,..... hiatal hernia, esophageal hernia?	____	____
18.	Do you have Epilepsy or Seizures?.....	____	____
19.	Have you ever had a heart attack?.....(Hospitalized for how long?)... What year?_____	____	____
20.	When was the last time you had an EKG?_____		
21.	Have ever had any chest pains? When and Where?..... Do they occur with exercise or at rest?..... Have you had a stress test, echocardiogram, or cardiac catheterization?.....	____	____
22.	Has any member of your immediate family ever had a heart attack?.....	____	____
23.	Do you take any medecine to rid your body of fluid?.....	____	____
24.	Do you have any swelling of your ankles?.....	____	____
25.	Personal or family history of neurological disorder and/or psychiatric disorder: Please list:_____		
26.	Do you have or have had any serious illness or condition: Please list:_____ _____		
27.	Female only: Are you pregnant?_____ LMP_____ COMMENTS_____ _____		

Patient Signature:_____ Date:_____