Outpatient Surgery Center of Central Florida

# NOTICE TO PATIENTS:
# Physician Financial Ownership

**Physician Financial Ownership**
We are required by Federal law to notify you that physicians hold financial interest or ownership in this ASC. We are required by 42 C.F.R. § 416.50 to disclose this financial interest or ownership in writing and in advance of the date of the procedure. A list of physicians who have a financial interest in this ASC are listed below:

1. Dr. Abel Rivero
2. Dr. Brian Saluck
3. Dr. Georg Couturier
4. Dr. Hari Kannam
5. Dr. Javier Gonzalez
6. Dr. Nishant Nerella
7. Dr. Nitza Alvarez
8. Dr. Rafik Abadier
9. Dr. Srinivas Attanti
10. Dr. Suman Pasupuleti
11. Dr. Vinod Miryala
12. North America Health Services Inc.

My signature below indicates that I have read and understood the above Policies and Procedures and that I have had the opportunity to ask questions with the understanding of the answers.

_____ _____

Signature Date

_____

Printed Name

Outpatient Surgery Center of Central Florida

# Medication Management

Dear Patient,

Proper management of your medications is important to your Care Plan. It is our goal to work with you to maintain an accurate medication list and keep you educated about their interactions, side effects, and effectiveness when taken correctly.

We may require you to bring in your medications in their original pill bottles in order to verify the name of the medication, the dosage and the frequency, and if any additional medications have been added. We also like for you to bring in any pain medication you may be taking, as certain types of medications will not be available in the Surgery Center.

**Prescription Refills:**

Outpatient Surgery Center is not a dispensing pharmacy and is compliant with Electronic Prescription requirements, therefore:

Only prescribed medications related to your procedure will be provided.

Refills will not be provided. If you need a refill the pharmacist is in the best position to safely and accurately coordinate the request with your provider.

If your prescription has expired, contact your provider as an office visit my be required to process a new prescription.

If your prescription medication requires authorization from your insurance or you use a mail order pharmacy, allow at least 30 days for this process to be completed.

Thank you for your cooperation, as it is our goal to keep everyone informed, and educated to provide the best informed and accurate care to you.

_____ _____

Signature Date

_____

Printed Name

Outpatient Surgery Center of Central Florida

# HIPAA Release Form

Patient Name _____ Date of Birth _____

As a courtesy to you and your referring physician, Outpatient Surgery Center of Central Florida will share the results of your procedure with your primary care physician, cardiologist and facilities/physicians deemed necessary by your procedural physician for continuity of care. In addition, I hereby authorize and request Outpatient Surgery Center of Central Florida to release my Protected Health Information (PHI) including images and/or reports to the following physicians/facilities:

_____

_____

In addition to the authorization for release of my PHI described above this authorization, I furthermore acknowledge that I have the right to authorize access and disclosure of my billing, condition, treatment and prognosis to the following individuals:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I request the following restriction(s) to releasing my PHI:

_____

_____

I understand that I have the right to revoke this authorization **in writing** at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance of my authorization or if authorization was obtained as a condition of obtaining insurance coverage and the insurance has a legal right to contest a claim. Unless otherwise revoked, this authorization shall be enforced in effect one year from today's date at which time, this authorization expires.

_____ _____ _____

Patient / Authorized Representative Signature | Relationship Other Than Patient | Date

Outpatient Surgery Center of Central Florida

# Outpatient Surgery Center Packet
# Acknowledgment of Policies and Procedures



My signature below indicates that I have read and understood the above Policies and Procedures and that I have had the opportunity to ask questions with the understanding of the answers.

_____ _____

Signature Date

_____

Printed Name

| | Yes | No |
|---|---|---|
| I have an advance directive. | ☐ | ☐ |
| I would like more information about advance directives. | ☐ | ☐ |

Information Packet Given as Requested _____ Initials