

TAMPA BAY ENDOSCOPY CENTER

PLEASE COMPLETE THE ENTIRE PACKET AND RETURN TO THE FRONT DESK WHEN CALLED

Name: _____

Date of Birth: _____ Social Sec. #: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home #: _____ Work #: _____ Cell#: _____

Marital Status: Single Married Divorced Widowed

Race/Ethnicity: American Indian Asian/Pacific White/ Hispanic

 Black /Hispanic White/ Caucasian Black/ African American

Guarantor Name: _____

Date of Birth: _____ Social Sec. #: _____

I have received verbal and written notice of my patient rights and responsibilities prior to my procedure.
Yes _____ No _____.

In accordance with Federal ASC Regulations (42C.F.R.416.50 (a) (ii)), It has been disclosed in writing prior to my procedure, that Tampa Bay Endoscopy Center is owned in part by Physicians. By signing below, I acknowledge that this disclosure has been made in advance of the date of procedure, and that I have decided to have the procedure performed at Tampa Bay Endoscopy Center.
Yes ____ No _____.

IN THE EVENT THAT I AM TRASFERRED TO AN ACUTE CARE FACILITY (HOSPITAL), I AUTHORIZE THE ACCEPTING FACILITY TO RELEASE MY MEDICAL RECORDS GENERATED FROM THE ADMISSION TO TAMPA BAY ENDOSCOPY CENTER. I AM ALSO AWARE THAT ANY EXPENSES INCURRED BY A TRANSFER TO ACUTE CARE FACILITY ARE MY RESPONSIBILITY.

Advance Medical Directives

1. Do you have a living will? Yes _____ No _____ If Yes; where is it located? _____

2. Do you have a Durable Power of Attorney for your healthcare or an appointed Health Care Surrogate?
Yes _____ No _____.

3. If yes, who? _____ Where is document located? _____

4. Would you like information about Advance Directives? Yes _____ No _____.

5. I understand that Advance Directives are not intended for use in ambulatory surgery centers such as Tampa Bay Endoscopy Center. Yes _____ No _____.

THE FINANCIAL AGREEMENT, PAYMENT POLICY AND BILLING PROCEDURES HAVE BEEN DISCUSSED WITH THE PATIENT/GUARANTOR AND COPIES OF EACH HAVE BEEN GIVEN TO THE PATIENT/ GUARANTOR.

PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____

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