SURGERY CENTER OF LAKELAND HILLS BLVD

REGISTRATION FORM

(Please Print)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Race:	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

INSURANCE INFORMATION

(Please give your insurance card(s) and photo identification to the receptionist.)

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ MEDICARE	☐ MEDICAID	☐ BCBS	☐ UHC	☐ CIGNA
☐ POLK HEALTH	☐ UNIVERSAL HCARE	☐ SELF PAY	☐ MEDICARE COMPLETE	☐ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

ADVANCE MEDICAL DIRECTIVES

DO YOU HAVE A LIVING WILL? YES NO WHERE? HOME HOSPITAL_____ ATTORNEY _____OTHER _____

DOES SOMEONE OTHER THAN YOURSELF HAVE DURABLE POWER OF ATTORNEY FOR YOUR HEALTH CARE? YES NO WHO? _____

WOULD YOU LIKE INFORMATION ABOUT ADVANCE DIRECTIVES? YES NO

I UNDERSTAND THAT ADVANCED DIRECTIVES ARE INTENDED FOR USE IN AMBULATORY SURGERY CENTERS SUCH AS THE SURGERY CENTER OF LAKELAND HILLS BLVD.

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the facility. I understand that I am financially responsible for any balance. I also authorize Surgery Center of Lakeland Hills Blvd or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

SURGERY CENTER OF LAKELAND HILLS BOULEVARD

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charge, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and/or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Surgery Center of Lakeland Hills Boulevard, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to the procedure that the physicians who perform procedures/service at Surgery Center of Lakeland Hills Boulevard may have an ownership interest in Surgery Center of Lakeland Hills Boulevard . The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Surgery Center of Lakeland Hills Boulevard.

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

I hereby acknowledge that a copy of the Notice of Privacy Practices for Surgery Center of Lakeland Hills Boulevard has been made available to me. I have the right to obtain a paper copy upon request (Version 3.0).

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

PATIENT RIGHTS/ADVANCED DIRECTIVE INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to the date of the procedure. I have also received information regarding Surgery Center of Lakeland Hills Boulevard policies pertaining to ADVANCE DIRECTIVES prior to the procedure. ADVANCED DIRECTIVES will be honored within the Center.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

_____ _____

Signature of Patient or Responsible Party | Print Name

_____ _____

Relationship to Patient | Date Signed / Time

SURGERY CENTER OF LAKELAND HILLS BLVD.

The Lakeland FL Endoscopy
D/B/A The Surgery Center of Lakeland Hills Blvd.
3340 Lakeland Hills Blvd.
Lakeland, FL 33805

ANESTHESIA PROFESSIONAL SERVICES
PATIENT CONSENT - BUSINESS AND ADMINISTRATION

FINANCIAL AGREEMENT: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the APS charges (including but not limited to insurance companies, health care service plans, or worker's compensation carriers).

Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay the APS for all such services, at the APS regular rates and terms should my insurance company deny payment. I shall also be responsible for any deductibles or co-pay owed at the time of services. Should this account be referred for collection to any attorney or collection agency, I shall pay all attorneys' fees and collection expenses in connection therewith, if the patient's account is delinquent. I shall be responsible for paying the center interest on the full outstanding balance at the maximum rate allowed by laws.

I hereby certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act or by any other payor is correct. I assign to the Anesthesia Professional Services, all benefits due me under the terms of said policies and programs but not to exceed the APS regular charges for similar services.

_____ _____
Initial here

This consent is valid for one year after the initial signature or until changes have been made in my insurance coverage or the attending physician.

_____
FULL SIGNATURE of Patient/Parent/Guardian

_____
FULL SIGNATURE of Witness

Date:_____

PATIENT LABEL HERE

2133-05

SCL-AnesthProfSer
REV. 01/06/12

Authorization to Release Protected Health Information

Patient Name	
DOB	
Last Four Digits of SS #	

Release Information From:

Practice/Organization Name	
Practice/Organization Address	
Phone #	
Fax #	

Release Information To: Surgery Center of Lakeland Hills Boulevard
3340 Lakeland Hills Boulevard
Lakeland, FL 33805
863-682-3239 (Phone) 863-682-3462 (Fax)

INFORMATION TO BE RELEASED:
Clinic/Hospital Notes, Operative Reports, Pathology Reports, Laboratory Reports, Radiology Reports, Discharge Summary for service dates: _____.

REVOCATION - I understand that I may revoke this authorization at any time by sending a written notice to the Center. However, the revocation will not have any effect on any uses or disclosures the Center may have made before the revocation was received.
EXPIRATION - I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed.
REDISCLOSURE - I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.
REFUSAL - I understand that I may refuse to sign this authorization and that the Center will not condition treatment on whether I sign this authorization.

Signature: _____ **Date Signed:** _____

Printed Name of Person Signing (If Not Patient): _____

Relationship to Patient: _____

SURGERY CENTER OF LAKELAND HILLS BLVD.

PATIENT MEDICAL HISTORY

Name: _____

Please check all that apply.

- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Chest Pain
- ❑ Congestive Heart Failure
- ❑ Cardiac catherization and/or angioplasty
- ❑ Open heart surgery
  - ❑ Bypass
  - ❑ Valve replacement
- ❑ Pacemaker / AICD
- ❑ Rheumatic fever
- ❑ Irregular heart rhythm
- ❑ Valve disease and/or murmur
- ❑ Smoker PPD ___ Quit ___
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Sleep Apnea
- ❑ Cancer
- ❑ Dialysis
- ❑ Renal failure
- ❑ Kidney stones
- ❑ Difficulty urinating
- ❑ Hepatitis
- ❑ Alcohol use How Much? _____
- ❑ Glaucoma
- ❑ Strokes/Ministrokes
- ❑ Seizures
- ❑ Myasthenia Gravis
- ❑ Ulcers
- ❑ Hiatal Hernia
- ❑ Heartburn
- ❑ Anemia
- ❑ Blood Disorders
- ❑ High Cholesterol
- ❑ Diabetes
- ❑ Thyroid Problem
- ❑ Artificial joints
- ❑ Metal implants
- ❑ Lens implants
- ❑ Arthritis
- ❑ Prosthesis

Female Only

- ❑ Post Menopausal
- ❑ Last menstrual period _____
- ❑ Hysterectomy
- ❑ Tubal Ligation

Reviewed by RN _____

PATIENT LABEL HERE

PATIENT MEDICATION RECONCILIATION Form

AmSurg Center Non-System Policies

Name:	Date of Birth:	Age:
Allergies: ☐ Yes ☐ No known allergies	Latex Allergy ☐ No ☐ Yes ☐ Testing performed for Latex allergy	

Allergy (Drug)	Reaction	Allergy (drug)	Reaction

Current Prescriptive Medications.

Name of Medication (print please)	Dose	How Often	Last Dose	Continue After Discharge	Stop After Discharge

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.

Name of Medication (print please)	Dose	How Often	Last Dose	Continue After Discharge	Stop After Discharge

Signature of person filling out form_____Date:_____

New Medications or New Dosages you should take after discharge.

Name of Medication (print please)	Dose	How Often	Continue After Discharge	Stop After Discharge

Signature of Patient/Responsible Person:_____Date:_____

Nurse Signature:_____Date:_____

Physician Signature:_____Date:_____

SURGERY CENTER OF
LAKELAND HILLS BOULEVARD

Please complete ONLY the TOP section of this form!

Patient Name _____ Date of Procedure _____

Which procedure are you having today?

_____ Colonoscopy _____ EGD/Throat Scope _____ Both _____ Im not sure

Please provide a phone number where we can reach you to follow-up on your recovery ***after*** your visit today: _____

If you are not available when we call the number you provided, do we have your permission to speak with someone else? Yes _____ No _____

If YES, what is that persons name? _____
What is this persons relation to you? _____

Do we have permission to discuss financial information with this person? Yes _____ No _____

_____ I do not wish to be contacted regarding my recovery.

Who will be driving you home today? _____
What is their phone number? _____

Patient Signature _____ Date _____

STOP! DO NOT WRITE BELOW THIS LINE! OFFICE USE ONLY!

Questions		Comments
Have you had any rectal Bleeding?	☐ Yes ☐ No	
Have you had any discomfort?	☐ Yes ☐ No	
Have you had to take any meds for pain?	☐ Yes ☐ No	
Have you had a fever? (temp_____)	☐ Yes ☐ No	
Have you been able to tolerate food/fluids?	☐ Yes ☐ No	
Have you had nausea/vomiting?	☐ Yes ☐ No	
Did you understand your post-op		
instructions, including medications?	☐ Yes ☐ No	
Did you have to call your physician or go		
to the ER/Urgent care?	☐ Yes ☐ No	
Were you satisfied with your care?	☐ Yes ☐ No	

Date/Time of Call _____ Spoke with _____ Caller _____

Attempt #1 Date/Time: _____ By: _____
Attempt #2 Date/Time: _____ By: _____

☐Message left on voicemail to call the center if the patient has any concerns.
Date/Time: _____ By: _____
☐Letter/post card mailed to patient.
Date/Time: _____ By: _____

Patient Label

If you have questions regarding your bill, please refer to the following contact information

For Facility charges:

Surgery Centery of Lakeland Hills Blvd
The Lakeland FL Endoscopy ASC, LLC
3340 Lakeland, FL 33805
863-682-3239 phone
863-682-3462 fax

For Anesthesia charges:
Zotec
1-855-496-3581
Dr. John Woody

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For Pathology charges:
Micro Path Labs
863-683-7171

EndoChoice
866-588-3280

Miraca Life Sciences
800-979-8292

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For Surgeon charges:
Dr. Lamport
1222 South Florida Ave.
Lakeland,FL 33803
863-688-7990 phone
863-688-1335 fax
****
Dr. Vargas
1114 South Florida Ave.
Lakeland, FL 33803
863-687-8335 phone
863-687-8337 fax
****
Dr. Moquete
2112 Lakeland Hills Blvd.
Lakeland, FL 33805
863-688-0540 phone
863-683-9805 fax
****
Dr. Haque
508 E. Garden Street
Lakeland, Florida 33805
863-802-1111 phone
863-802-6711 fax
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