Outpatient Surgery Center of Boca

CONSENT FOR SURGICAL TREATMENT

I understand that as the patient or patient's guardian, I am responsible for providing the *Outpatient Surgery Center of Boca* with the most accurate and complete information regarding present complaints, past illnesses, hospitalizations, medications, unexpected changes in my/the patient's condition, or any other health matters.

I HAVE READ THIS CONSENT OR IT HAS BEEN READ TO ME, AND I FULLY UNDERSTAND IT AND THE POSSIBLE RISKS, COMPLICATIONS, AND BENEFITS THAT CAN RESULT FROM THE SURGERY. I ACCEPT ON BEHALF OF MYSELF/THIS PATIENT ALL OF THE ITEMS LISTED BELOW.

I HEREBY AUTHORIZE DR. _____ AND/OR SUCH ASSISTANTS HE/SHE MAY SELECT, TO PERFORM THE FOLLOWING SURGERY ON MY _____.

SURGERY: _____

This will be filled in at the surgery center the day of your surgery.

_____

_____

_____ _____

Printed name of patient **Signature of Surgeon**

_____ _____

Signature of patient **Signature of guardian**

_____ _____

Signature of witness **Date**

Patient unable to give consent due to: _____

□ Interpreter utilized via: staff/ family member/ AT&T line interpreter # _____

Optimal Anesthesia

INFORMATION AND CONSENT FOR ANESTHESIA SERVICES

It is very important that you, the patient, read this consent form carefully. If you have any questions after reading this form, they may be directed to the Anesthesiologist in person on the day of surgery. Upon request, the Anesthesiologist will contact you at your convenience for questions.

The type of anesthesia you will have is called monitored anesthesia care. This means that you will have an intravenous line started and routine monitors applied. You may be given a mild sedative. Medication may be applied to you operative eye to make it numb for surgery, this is called topical anesthesia. In some cases, topical anesthesia may be insufficient. In this case, an injection of medication is given below, and sometimes above your eye, this is called a block. Prior to the block, you will be given a medication through the intravenous line to render you unconscious for a few minutes while the injection is being given. Whether or not a block is performed, you will most likely be awake during the surgery, but should not experience any discomfort.

Complications of anesthesia are relatively uncommon, but can happen. It is important that you understand that there are risks undergoing any type of anesthesia, including general, intravenous sedation, spinal, epidural, local, nerve block, or regional anesthesia. While it is impossible to advise you of every conceivable complication, some possible complications are as follows:

Nausea and vomiting.
Aspiration (inhaling vomitus into lungs) and pneumonia.
Nerve injuries and possible weakness and paralysis.
Untoward reactions that can involve allergic type reaction or even cardiac arrest and death.
Soreness, bruising, or phlebitis at the site of the intravenous catheter.
Perforation of the eyeball, bleeding, or loss of vision.
Medical complications can occur at any time including, but not limited to heart attack, stroke, abnormal heart rhythm, seizures, and difficulty breathing requiring placement of an endotracheal (breathing) tube that may necessitate transfer to a local hospital.

In order to minimize the possibility of food going into the lungs, the patient is required not to eat or drink anything for a period of at least 8 hours before surgery. In most cases we ask that you have nothing to eat or drink after midnight prior to surgery.

I understand that the surgeon will be occupied primarily with the surgery, and that the administration, maintenance, and termination of anesthesia are independent functions and will be supplied by, and are the responsibility of the **Anesthesiologist or Certified Registered Nurse Anesthetist** delivering the anesthesia.

I hereby consent to the administration of anesthesia considered necessary or advisable.

I have read or have had read to me and understand all of the above.

_____	_____	_____
Signature of patient/guardian	**Signature of witness**	**Date**

Outpatient Surgery Center of Boca

INFORMED CONSENT FOR OCULAR SURGERY

This information is given to you so that you can make an informed decision about having surgery in an attempt to restore the eye and vision. Take as much time as you wish to make your decision prior to signing this form. You have the right to ask any questions that you may have before agreeing to have the surgery.

Complications of surgery: As a result of any surgery to the eye, it is possible that your vision could be made worse. In some cases, complications may occur weeks, months, or even years later. Complications may include vitreous prolapse, corneal graft (transplant) rejection or failure, astigmatism, bleeding, failure of healing, infection, loss of corneal clarity, lid droop, loss of lens material into back of eye, dislocated lens, detachment of the retina, glaucoma, double vision, or possible need for additional surgery. These and other complications may result in poor vision, total loss of vision, or loss of the eye or subsequent admission to the hospital.

Complications of surgery in general: As with all types of surgery, there is a possibility of other complications, potentially fatal, due to anesthesia, drug reactions, or other factors which may involve other parts of your body. Since it is impossible to state every complication that may occur as a result of the surgery and anesthesia, the list of complications in this form is incomplete.

I understand the basic procedures of the surgery and my doctor has explained the advantages and disadvantages, risks, and possible complications and alternative treatments for me. Although it is impossible for my doctor to inform me of every complication that may occur, the doctor has answered all of my questions to my satisfaction. In signing this informed consent for ocular surgery, I understand the consent I am giving and the possible risks, complications, and benefits that can result from the surgery.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me to the results of the surgery.

I understand that occasionally a sales representative or individual approved by my surgeon may be in attendance during my surgery.

I consent to taking of photographs for medical use only.

I consent to the administration of anesthesia as required for the surgery. Should I have any questions regarding the administration of anesthesia, I will discuss them at length with the Anesthesiologist prior to surgery.

In the event that any member of the staff involved in my care is exposed to my blood, bodily fluids, or other contaminated materials, I agree to allow testing that will determine the presence of H.I.V. and hepatitis. An accredited laboratory, at no cost to me, will perform all required laboratory tests.

I understand that if I am pregnant or if there is any possibility that I may be pregnant, I must inform the surgeon **immediately** since having the surgery could harm my myself or my child.

I acknowledge that I have been advised by the surgery center personnel that I should not drive until the effects of any medications that I receive have worn off. I understand that I should not drive until the day after my operation, at the earliest.

I understand that I must be discharged in the company of a responsible adult, unless exempted by my physician; this person will be available to provide assistance to me if needed for 24 hours following my surgery.

I release Outpatient Surgery Center of Boca from any and all responsibility for the loss and/or damage to money, jewelry, or other valuables brought into the facility.

I recognize that during the course of the surgery, unforeseen conditions may necessitate additional or different procedures. Therefore, I further authorize and request that my surgeon and his/her assistants perform such procedures that are, in his/her judgment, necessary and desirable. The authority herein granted shall extend to remedying conditions that are not known to my surgeon at the time the surgery is started.

I understand that I may obtain information concerning this treatment from one of the following sources: **my surgeon, the American Academy of Ophthalmology, or the American Medical Association.**

I understand that should I suffer a cardiac or respiratory arrest or other life threatening situation, my signature on this form implies consent for resuscitation and transfer to a higher level of care (hospital, trauma center, etc.). Therefore, in accordance with state and federal laws, **this facility is notifying you that it will not honor any previously signed advance directives by you to withhold cardiac or respiratory resuscitation**. If you disagree with this implied consent for resuscitation, you must address this issue with your physician prior to signing this consent form.

_____	_____	_____
Signature of patient/guardian	**Signature of witness**	**Date**

Outpatient Surgery Center of Boca

I. NOTICE OF POLICY REGARDING ADVANCED DIRECTIVES

In order to be in compliance with the Self-Determination Act (PSDA) and Florida law and rules and regarding advanced directives, I have received verbal and written information concerning the Center's policies. Advanced directives are statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The advance directives are made and witnessed prior to serious illness or injury. There are many types, but the most common forms are:
Living Will: This generally states the type of medical care an individual wants or does not want if he/she becomes unable to make his/her own decisions.
Durable Power of Attorney for Health Care: This is a signed, dated, and witnessed paper naming another person as an individual's agent or proxy to make medical decisions for that individual if he/she should become unable to make his/her own decisions.

We respect the rights of patients to make informed decisions regarding their care. The center has adopted the position that an ambulatory surgery setting is not the most appropriate setting for end of life decisions. There fore it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made. If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

I **have** executed an advance directive ☐ NO ☐ YES ☐ Copy in chart or location of: _____

II. NOTICE OF DISCLOSURE OF OWNERSHIP INTEREST

I have received written disclosure of information regarding physician financial interests or ownership in the Center**.** The Outpatient Surgery Center of Boca is owned by a corporation including local physicians, one of whom may be your physician. Under current Florida law, a physician-owned facility may not provide items or services to a patient unless the patient signs a written notice disclosing certain matters. Please be advised that the Outpatient Surgery Center may have a financial relationship with your physician. A schedule of typical fees for services provided by the Surgery Center is available at your request. You have the right to choose where to receive services, including an entity in which you may have a financial relationship. Reasonable alternative sources of services available are: **Boca Raton Outpatient Surgery and Laser Center 561-362-4400 Delray Surgery Center 561-495-9111** By providing these names, the Surgery Center is merely complying with legal requirements.

III. H.I.V. INFORMED CONSENT

In accordance with federal and state law, when signed, this form will indicate authorization and consent to obtain blood from me for the purpose of conducting a H.I.V. test **in the event of blood or fluid exposure to medical personnel involved in my care.** In the event that such exposure does occur, I understand that it will be documented in my record and I will be notified. I understand that the H.I.V. test is not 100% reliable and may, in some cases, indicate a false positive or false negative. I understand that a positive blood test result does not mean that I have A.I.D.S., and that in order to diagnose, a second or confirmatory test may be necessary before any test results are released. I will be provided with an opportunity for face to face counseling. I understand that if there is a positive test result, those health care practitioners who are directly responsible for my care and treatment will be informed of this result so that proper precautions may be observed. I further understand that any information regarding my test results held by the health care facility, its employees, or agents, any physician, laboratory, or blood bank, any insurance company, health benefit plan, Medicare/Medicaid, or other third party payor, the Department of Health, or any agency shall be strictly confidential and shall not be disclosed to any other agency or institution or made public, except where my personal identifiers are removed from such information. ***By my signature below, I acknowledge that I have read this consent form and understand the provisions for release of information set forth in this consent.***

IV. TRANSPORTATION WAIVER

I release the Outpatient Surgery Center of Boca from any responsibility while I am traveling to or from the Center.

V. RELEASE OF MEDICAL INFORMATION/ BENEFIT ASSIGNMENT CONSENT

Permission is hereby granted to the Center for the release of medical information necessary for the completion of the patient's claim for insurance compensation. This permission is also granted to these parties for Medicare claims filed under Title XVIII of the Social Security Act. This admission is subject to the current credit policies of the Center. The patient agrees to assume full financial responsibility for any balance or fee not covered by the insurance carrier or other third party. Authorization is hereby granted for payment to be made directly to the Center. All group or individual insurance or third party benefits payable for services related to this admission.

VI. PATIENT RIGHTS AND RESPONSIBILITIES

I have received verbal and written notification of the patient's rights and understand the policies setting forth my rights and responsibilities as a patient admitted to this Center.

I have read and fully understand the information presented to me in this release notification.

_____ _____ _____

Signature of patient/guardian **Signature of witness** **Date**

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures
Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures
We may be required or permitted to use or disclose the information even without your permission as described below:
Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.
Law Enforcement Purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.
Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.
▫You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out of pocket for the item or service covered by the request and when the uses or disclosures are not required by law.
▫You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
▫In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.
▫You have the right to request that we amend your information.
▫You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
▫You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact the Center Leader of:
Outpatient Surgery Center of Boca
950 NW 13th Street, Boca Raton, FL 33486
(561) 391-7642

Effective Date: March 26, 2013

I, _____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement

Signed: _____

Date: _____

Outpatient Surgery Center of Boca

Patient Rights and Notification of Physician Ownership

Patient's Bill of Rights:

Every patient has the right to be treated as an individual and to actively participate in his/her care. The facility and medical staff have adopted the following patient rights and responsibilities, which are communicated to each patient or the patient's representative or surrogate in advance of the procedure/surgery.

Patient's Rights:

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
A patient has the right to a prompt and reasonable response to questions and requests.
A patient has the right to know who is providing medical services and who is responsible for his or her care.
A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
A patient has the right to know what rules and regulations apply to his or her conduct.
A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
A patient has the right to refuse any treatment, except as otherwise provided by law.
A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or healthcare facility accepts the Medicare assignment rate.
A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

Patient's Responsibilities:

The patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
The patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
The patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
A patient is responsible for following the treatment plan recommended by the health care provider.
A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
A patient is responsible for his or her actions should he or she refuses treatment or does not follow the health care provider's instructions.
A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

If you need an interpreter:

If you will need an interpreter, **please let us know** and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

Rights and Respect for Property and Person:
The patient has the right to:
Exercise his or her rights without being subjected to discrimination or reprisal.
Voice a grievance regarding treatment or care that is, or fails to be furnished.
Be fully informed about a treatment or procedure and the expected outcome before it is performed.
Confidentiality of personal medical information.

Privacy and Safety:

The patient has the right to:

Personal privacy.
Receive care in a safe setting.
Be free from all forms of abuse or harassment.

Advance Directives:

You have the right to information regarding advance directives and this facility's policy on advance directives. Applicable state forms will be provided upon request.

The surgery center is not an acute care facility; therefore, regardless of the contents of any advanced directive or instructions from a health care surrogate, if an adverse event occurs during treatment, patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family. If they have been provided to the surgery center, a copy of the patient's advance directives will be sent to the acute care facility with the patient.

If the patient or patient's representative wants their advance directives to be honored, the patient will be offered care at another facility that will comply with those wishes.

Complaints/Grievances:

If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to center management for resolution. You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken.

The following are the names and or agencies you may contact:
Andrea Spoto RN, BSN
Center Director Outpatient Surgery Center of Boca
950 NW 13th Street
Boca Raton, Florida 33486
561-391-7642

You may contact the state to report a complaint:
Florida Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C-75
Tallahassee, Florida 32399-3275
Phone (850)245-4339 or TF 1-888-419-3456
http://www.doh.state.fl.us/mqa/enforcement/enforce_csu.html

Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman at www.medicare.gov/Ombudsman/resources.asp

Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

Office of the Inspector General: http://oig.hhs.gov

This facility is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Complaints or grievances may also be filed through:
AAAHC
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
847-853-6060 or email: info@aaahc.org

Physician Financial Interest and Ownership:

The center is owned, in part, by the physicians. The physician(s) who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations.

The following physicians have a financial interest in the center:
Howard Goldman MD, Mark Weiner MD, Douglas Kohl MD, Ernesto Segal MD, Richard Kalski MD, and Tatiana Lee Chee DO