BEFORE YOUR PROCEDURE **CLAY SURGERY CENTER**

How can I prepare for my procedure?

Read the following instructions carefully, as they have information on diet and what the doctors need to be aware of before the surgery/procedure. Following theses instructions ensure your comfort and reduce the possibility of complications or delays. We make every effort to adhere to schedule procedure times. However, occasional unforeseen delays may occur.

1. **Make arrangements for transportation**: You will **not** be able to drive yourself after your procedure. Please make sure there is a responsible adult here to take you home. Public transportation is **not** an acceptable means of transportation (bus, taxi etc.), unless accompanied by responsible adult.
2. **Diet: No solid foods for 6 hours prior to your scheduled procedure time. You may have up to 12 ounces of clear liquids (water, Gatorade, soda, tea, black coffee) until 4 hours prior to your procedure. Hydrate as much as possible the day prior to your procedure.**
3. **Bath or shower, and brush your teeth** the morning of your procedure (please do not swallow water). Do not apply perfumes, lotions or deodorants, please remove artificial nails and/or nail polish prior to your procedure.
4. **Medications: Please take medications with a small sip of water.** Please bring a current list of your medications with you the day of your procedure.
5. **Diabetics:** Please speak to the nurse regarding your medications, and what you should and should not take. **Please check your blood sugar the day of your procedure and if your blood sugar is over 200 please call the center at 904-264-0400.** If the doctor deems that your blood sugar is too high your procedure may be cancelled or rescheduled. **If you are on insulin please bring your diabetic medication with you.**
6. **Latex allergy**: Please let the nurse know the day before your procedure, if you have an allergy to Latex or rubber.
7. **Aspirin or Blood thinning meds**: Please inform your physician as soon as possible if you are taking aspirin or medications that can thin your blood. Your prescribing physician will need to be notified of the pending procedure in order to review and stop the medication several days before your procedure.
8. **Pacemaker/Defibrillator**: Please inform your physician if you have a Pacemaker and or Defibrillator. There may be adjustments/accommodations that need to be addressed prior to your procedure.
9. If you experience changes in your medical history or develop a cold or temperature prior to your procedure, please notify the center prior to your arrival.
10. **Leave all valuables at home**: Please leave all jewelry and/or valuables at home. The surgery center does not have a place to keep your valuables. **We will not be held responsible if your valuables should be lost or stolen.** Bring your eyeglasses so that you are able to sign your consents.
11. **Clothing:** Wear comfortable, loose, warm clothing.
12. **Bring your insurance cards and photo identification**.
13. Please advise someone from our staff if you have special communication needs on the day before your procedure.
14. It is our policy that **ALL** women of child-bearing age 8-55yrs will have a pregnancy test prior to procedure. If it is determined that you are a female patient of childbearing age and/or capacity, and you refuse a pregnancy test, your procedure may be cancelled.
15. **A representative from the surgical center will call you the day before your procedure and give you an arrival time. If you have not received a phone call by 3 pm the day before your procedure, please call us at: 904-264-0400.**
16. **You will be billed a $150.00 fee for cancellations not made more than 24 hours in advance of your scheduled procedure. Please note that this is not billable to your insurance carrier.**

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Reviewed again via phone by: _____ Date: _____

CLAY SURGERY CENTER
PATIENT REGISTRATION

PATIENT DEMOGRAPHICS

LAST NAME: FIRST NAME: MIDDLE NAME:

STREET ADDRESS:

CITY: STATE: ZIPCODE:

SEX: 0 MALE 0 FEMALE SOCIAL SECURITY # : DATE OF BIRTH:

CELL PHONE # : HOME PHONE # : WORK PHONE # :

PHONE MESSAGES- PLEASE CHOOSE ONE: 0 OKAY TO LEAVE DETAILED MESSAGES/INSTRUCTIONS 0 LEAVE MESSAGE TO CALL BACK ON

MARITAL STATUS: 0 MINOR 0 SINGLE 0 MARRIED 0 SEPARATED 0 DIVORCED 0 WIDOWED

CHECK APPLICABLE: 0 CAUCASIAN 0 AFRICAN AMERICAN 0 WHITE HISPANIC 0 BLACK HISPANIC 0 AMERICAN INDIAN 0 ASIAN/ PACIFIC ISLANDER 0 OTHER; PLEASE SPECIFY :

EMPLOYER NAME: EMPLOYER PHONE:

EMPLOYER ADDRESS:

IF STUDENT, NAME OF SCHOOL: CITY/ STATE: 0 FT 0 PT

SPOUSE/PARENT/ SIGNIFICANT OTHER'S NAME: PHONE:

MAY WE SPEAK TO THIS PERSON IN DETAIL IN REGARDS TO YOUR APPOINTMENTS/ PROCEDURES? 0 YES 0 NO

EMERGENCY CONTACT: RELATION: PHONE:

ACCIDENT RELATED INJURY INFORMATION OR CHECK HERE, IF NOT APPLICABLE: 0

(PLEASE COMPLETE IF SERVICES ARE DUE TO AN ACCIDENT)

CHECK TYPE OF ACCIDENT: 0 AUTOMOBILE 0 SLIP AND FALL 0 WORKER'S COMPENSATION 0 OTHER:

DESCRIBE HOW THE INJURY OCCURRED:

PLACE INJURY OCCURRED: DATE OF INJURY:

INSURANCE COMPANY NAME:

HAS YOUR INSURANCE COMPANY ASSIGNED A CLAIM # ? : 0 NO 0 YES-- CLAIM # :

CASE MANAGER/ADJUSTER NAME: PHONE # :

IF THIS IS AN AUTOMOBILE RELATED INJURY, HAS YOUR PIP HAS BEEN EXHAUSTED? : 0 YES 0 NO 0 UNSURE

ATTORNEY INFORMATION (PROVIDING ATTORNEY INFO DOES NOT GUARANTEE ACCEPTANCE OF LETTER OF PROTECTION)

ATTORNEY NAME: ATTORNEY FIRM:

ATTORNEY ADDRESS:

ATTORNEY PHONE: CONTACT REPRESENTITIVE:

HEALTH INSURANCE INFORMATION OR CHECK HERE, IF YOU HAVE NO HEALTH INSURANCE: 0

PRIMARY HEALTH INSURANCE COMPANY:

IDENTIFICATION NUMBER: GROUP NUMBER:

INS CO ADDRESS: INS CO PHONE NUMBER:

NAME OF POLICY HOLDER: RELATION TO PATIENT:

POLICY HOLDER DOB: POLICY HOLDER SSN:

POLICY HOLDER ADDRESS: POLICY HOLDER PHONE # :

POLICY HOLDER EMPLOYER:

SECONDARY HEALTH INSURANCE COMPANY OR CHECK HERE, IF NO SECONDARY: 0

IDENTIFICATION NUMBER: GROUP NUMBER:

INS CO ADDRESS: INS CO PHONE NUMBER:

NAME OF POLICY HOLDER: RELATION TO PATIENT:

POLICY HOLDER DOB: POLICY HOLDER SSN:

POLICY HOLDER ADDRESS: POLICY HOLDER PHONE # :

POLICY HOLDER EMPLOYER:

THE INFORMATION ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: **Date:** **Time:**

Clay Surgery Center

Date Submitted:					Date printed:	
Patient Demographics	Patient Name:				Preferred Name:	
	Home Phone:	Cell Phone:			Work Phone:	
	Height:	Weight:	BMI:	Sex: M / F	DOB:	
	*If you are a legal guardian, have power of attorney, or advanced directives (living will), please bring documentation.					
	Your Name:			Phone Number:		
	Relationship to patient:					
	Procedure Date:			Procedure Time:		
	Name of Surgeon:					
	Description of procedure:					
	Emergency Contact Name:			Phone Number:		
	Name of person driving patient home from surgery:					
	Name of person who will care for patient after surgery:					

Labwork	Has the patient had any of the following in perparation for surgery? If yes, please include date/location				
	Have you had an EKG done in perparation?	yes	no	where:	date:
	Have you had any x-rays in preparation?	yes	no	where:	date:
	Have you had any blood tests in preparation?	yes	no	where:	date:
	Have you had anything else done in preparation?	yes	no	where:	date:
	If yes, explain:				

	Question	yes	no	Comments/Explanation:
Allergies	Drug allergies? (please list)	yes	no	Drug/Allergy:
	Do you have any food allergies? (please list)	yes	no	
	Latex/rubber allgergies?	yes	no	
	Other known allergies? (please list)	yes	no	
	Other abnormal drug reactions? (explain)	yes	no	
Diabetes	Are you diabetic?	yes	no	
	Is your diabetes diet controlled?	yes	no	
	Do you use (circle one): Injectible insulin / Oral Medications / Insulin Pump			
	Do you have hypoglycemia?	yes	no	
Anesthesia	Have you or anyone in your family had an unusual reaction to anesthesia such as high temp, difficulty waking up, nauseau and/or vomitting?	yes	no	

Surgical History	Procedure:			Date:
	Procedure:			Date:
	Procedure:			Date:
	Procedure:			Date:
	Procedure:			Date:
	Procedure:			Date:
	Were you able to list ALL of your surgeries above?	yes	no	Please include procedure/date on back if not
	Do you have any implants or prosthesis?	yes	no	
	Type:	Location:		Date:
	Type:	Location:		Date:

Patient Name:

Medications	Is the patient currently taking any medications? (herbal, prescribed, over-the-counter, steroids, diet pills, other)	yes / no	If yes, please include name/dosage/how often below:	
	1.	Dosage:	How often:	
	2.	Dosage:	How often:	
	3.	Dosage:	How often:	
	4.	Dosage:	How often:	
	5.	Dosage:	How often:	
	6.	Dosage:	How often:	
	7.	Dosage:	How often:	
	8.	Dosage:	How often:	
	Did your doctor instruct you to stop taking any medications in preparation for surgery?	yes / no	If yes, please include name/dosage/last taken:	
	1.	Dosage:	Last Taken:	
	2.	Dosage:	Last Taken:	
	3.	Dosage:	Last Taken:	
	4.	Dosage:	Last Taken:	
	Did your doctor instruct you to take any medications before you come to the center for surgery?	yes / no	If yes, please include name/dosage/time taken:	
	1.	Dosage:	Time Taken:	
	2.	Dosage:	Time Taken:	
	3.	Dosage:	Time Taken:	
	4.	Dosage:	Time Taken:	
	Were you able to list All of your medications above?	yes / no	Please include name/dosage on back if not	

Doctors	Please list physicians who care for you on a regular basis and/or during the past year (include primary care)		
	Physician:	Specialty:	Phone:
	Physician:	Specialty:	Phone:
	Physician:	Specialty:	Phone:
	Physician:	Specialty:	Phone:
	Physician:	Specialty:	Phone:

	Question	yes	no	Comments/Explanations:
Impairments/ Disabilities	Do you have any hearing impairments?	yes	no	
	Vision impairments? Including glasses/contacts?	yes	no	
	Mobility impairments?	yes	no	
	Artificial limbs?	yes	no	
	Will you need help reading the written information given to you at our center?	yes	no	
	Other impairments/disabilities? (explain)	yes	no	
Dental	Do you have any dentures/bridges?	yes	no	Comments/Explanations:
	Caps or crowns?	yes	no	
	Chipped or loose teeth?	yes	no	
	Do you wear any retainers?	yes	no	
Skin	Do you have any burns?	yes	no	Comments/Explanations:
	Rashes?	yes	no	
	Bruises?	yes	no	
	Other skin conditions? (explain)	yes	no	
	Does your skin tear easily?	yes	no	

Patient Name:

	Question	yes	no	Comments/Explanations:
Stomach	Do you have ulcers or hiatal hernia?	yes	no	
	Acid reflux disease?	yes	no	
	Gallbladder conditions?	yes	no	
	GI/rectal bleeding?	yes	no	
Psychiatric	Have you ever been treated for depression?	yes	no	
	Anxiety or panic discorder?	yes	no	
	Substance abuse?	yes	no	
	Developmental delays?	yes	no	
	Other psychiatric conditions?	yes	no	
Neurological	Have you ever had a stroke or TIA? (give dates)	yes	no	Date:
	Have you ever had any seizures?	yes	no	
	Do you suffer from any paralysis? (explain)	yes	no	
	Do you have Alzheimer's?	yes	no	
	Parkinson's?	yes	no	
	Other neurological conditions? (explain)	yes	no	
Musculoskeletal	Do you have any neck, back, or jaw problems?	yes	no	
	Joint replacement or dislocation?	yes	no	
	Muscular dystrophy?	yes	no	
	Arthritis?	yes	no	
	Other musculoskeletal conditions? (explain)	yes	no	
Hematologiscal & blood disorders	Have you ever had a blood transfusion?	yes	no	Date:
	Blood clots?	yes	no	
	Do you have sickle cell diesase?	yes	no	
	Anemia?	yes	no	
	Other blood conditions? (explain)	yes	no	
	Do you bruise easily?	yes	no	
	Are you taking any blood thinners?	yes	no	
	Are you taking aspirin or ibuprofen?	yes	no	
	Are you taking Vitamin E?	yes	no	
	Does your family have a history of hemophilia?	yes	no	
Liver	Do you have jaundice?	yes	no	
	Cirrhosis?	yes	no	
	Hepatitis? (list type)	yes	no	
Thyroid	Do you have hypothyroidism?	yes	no	
	Hyperthyroidism?	yes	no	
	Other thyroid conditions?	yes	no	
Kidney	Burning when urinating?	yes	no	Frequency:
	Bleeding when urinating?	yes	no	
	Are you on dialysis?	yes	no	
	Do you have any other urniary problems?	yes	no	

Patient Name:

	Question	yes	no	Comments/Explanations:
Pain	0-No pain; 1-2 hurts a little; 3-4 hurts a little more; 5-6 hurts even more; 7-8 hurts a whole lot; 9-10 hurts the worst			
	Do you have chronic pain?	yes	no	Location:
				Pain scale: (0-10)
				How long?
	Do you currently have pain associated with the condition for which you are having this procedure?	yes	no	Location:
				Pain scale: (0-10)
Cardiovascular	Do you have or have you ever had angina/chest pain?	yes	no	
	High blood pressure?	yes	no	
	Low blood pressure?	yes	no	
	Rheumatic fever?	yes	no	
	Congestive heart failure?	yes	no	
	Mitral valve prolapse?	yes	no	
	Heart surgery/stent/catheter?	yes	no	Date:
	Heart Attack?	yes	no	Date:
	Palpitations or an iregular heart beat?	yes	no	
	Do you use a pacemaker/defibrillator?	yes	no	Date:
				Type:
Pulmonary	Do you have asthma?	yes	no	
	Restrictive airway disease (RAD)/bronchitis/COPD?	yes	no	
	Sleep apnea?	yes	no	
	Do you have or have you ever been exposed to TB?	yes	no	
	Do you use a Nebulizer, Home breathing machine or Oxygen at home?	yes	no	
	Do you ever have shortness of breath?	yes	no	
	Do you smoke/use tobacco? (if yes, how much)	yes	no	Packs per day?
	Have you had a cold in the past 2 weeks?	yes	no	
	Have you traveled to a foreign country?	yes	no	When/Where:
Other	Do you drink alcohol?	yes	no	
	Do you use recreational drugs?	yes	no	
	Do you have any body piercings?	yes	no	
	Do you have any contagious diseases?	yes	no	
	Do you have or have you ever had cancer?	yes	no	
	Are you currently participating/enrolled in a medical research study?			
		yes	no	
	Have you been hospitalized in the last six months?	yes	no	Reason/date:
	Patient's primary langueage: English Spanish			Other:
	Will the patient need an interpreter?	yes	no	
	Will the patient bring an interpreter?	yes	no	Name:
Women	When was your last menstrual period? Date:			
	Are you pregnant or trying to get pregnant?	yes	no	
Minors	Was the patient born pre-mature?	yes	no	
	Are the patient's immunizations up to date?	yes	no	
	Does anyone in your home smoke or use tobacco?	yes	no	

Patient Name:

Special Needs or concerns:

Comments:

Patient Name:

Additional Medications and Supplements:		
1.	Dosage:	How often:
2.	Dosage:	How often:
3.	Dosage:	How often:
4.	Dosage:	How often:
5.	Dosage:	How often:
6.	Dosage:	How often:
7.	Dosage:	How often:
8.	Dosage:	How often:

Additional Stopped Medications:		
1.	Dosage:	Last taken:
2.	Dosage:	Last taken:
3.	Dosage:	Last taken:
4.	Dosage:	Last taken:
5.	Dosage:	Last taken:

Additional Presurgery Medications:		
1.	Dosage:	Time taken:
2.	Dosage:	Time taken:
3.	Dosage:	Time taken:
4.	Dosage:	Time taken:
5.	Dosage:	Time taken:

Additional Physician Information:		
Physician:	Specialty:	Phone:
Physician:	Specialty:	Phone:
Physician:	Specialty:	Phone:
Physician:	Specialty:	Phone:
Physician:	Specialty:	Phone:

Additional Surgical Procedures:	
Procedure:	Date:
Procedure:	Date:
Procedure:	Date:
Procedure:	Date:
Procedure:	Date:

Additional Implants/Prosthesis:		
Type:	Location:	Date:
Type:	Location:	Date:

RN/Reviewer's Signature:	Date:
Patient/Caregiver Signature:	Date:
Other Signature:	Date:

1564 Kingsley Avenue
Orange Park, FL 32073

ACKNOWLEDGMENT OF NOTICES

I acknowledge that I have received a copy of the following notices:

_____ Patient's Bill of Rights and Responsibilities

_____ Ownership Notice to Patients

_____ Notice of Policy Regarding Advanced Directives

_____ Privacy Practices / HIPAA

_____ Power of Attorney to Endorse Checks

_____ Insurance Company Payment Policy

_____ Authorization Release Information and Assignment Of Benefits

_____ _____

Patient's Signature Date

_____

Patient's Name Printed

Patient's Bill of Rights and Responsibilities

Section 381.026, Florida Statutes

A PATIENT HAS THE RIGHT TO:

- Be treated with courtesy and respect, with appreciation of his/her dignity, and with protection of privacy.
- Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and is responsible for his/her care.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his/her conduct.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given full information and necessary counseling on the availability of known financial resources for care.
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his/her consent or refusal to participate in such research.
- Express complaints regarding any violation of his/her rights.

A PATIENT IS RESPONSIBLE FOR:

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his/her health.
- Reporting unexpected changes in his/her condition to the health care provider.
- Reporting to the health care provider whether he/she understands a planned course of action and what is expected of him/her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His/her actions if treatment is refused or if the patient does not follow the health care provider's instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.

FILING COMPLAINTS

- If you have a complaint against a hospital or ambulatory surgical center, call the Consumer Assistance Unit at 1-888-419-2456 (Press 1) or write to the address below:

AGENGY FOR HEALTHCARE ADMINISTRATION
CONSUMER ASSISTANCE UNIT
2727 MAHAN DRIVE, BUILDING 1
TALLAHASSEE, FLORIDA 32308

- If you have a complaint about a health care professional and want to receive a complaint form, call the Consumer Services Unit at 1-888-419-3456 (Press 2) or write to the address below:

AGENGY FOR HEALTHCARE ADMINISTRATION
CONSUMER SERVICES UNIT
P.O. BOX 14000
TALLAHASSEE, FLORIDA 32317-4000

Agency for Health Care Administration
Visit us at www.FloridaHealthFinder.gov
Medicare Ombudsman, 1-800-MEDICARE
www.cms.gov/center/ombudsman.asp

OWNERSHIP NOTICE TO PATIENTS

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has an ownership interest, Florida passed a law (the "Patient Self-Referral Act of 1992," FL Statute Section 455.654). Under this law, I must disclose my ownership in CLAY SURGERY CENTER and tell you about alternative places where you may go to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care. You have a right to obtain healthcare items or services at a location or from the provider or supplier of your choice, including the facility in which I am owner. I assure you that you will not be treated differently if you do not choose the facility listed below in which I have an ownership interest.

Dr. Hemant Shah

Alternative facilities in which we do not have ownership:

Baptist Medical Center Downtown
800 Prudential Dr.
Jacksonville, Fl 32207
904-202-2000

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES

Advance directives **are not honored** at this facility and 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.

Signature Date

1564 Kingsley Avenue / Orange Park, FL 32073
Phone: 904.264.0400 / Fax: 904.264.0401
www.claysurgery.com

Health Care Advance Directives
The Patient's Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.

By law hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include 58A-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

Questions About Health Care Advance Directives

What is an advance directive?

It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are:

- A Living Will
- A Health Care Surrogate Designation
- An Anatomical Donation

You might choose to complete one, two, or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

What is a living will?

It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?

It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

Which is best?

Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

What is an anatomical donation?

It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of health care workers. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form (seen elsewhere in this pamphlet), or expressing your wish in a living will.

Am I required to have an advance directive under Florida law?

No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care or an anatomical donation may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, an adult relative, or a close friend.

The person making decisions for you may or may not be aware of your wishes. When you make an advance directive, and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?

No, the procedures are simple and do not require an attorney, though you may choose to consult one.

However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Where can I find advance directive forms?

Florida law provides a sample of each of the following forms: a living will, a health care surrogate, and an anatomical donation. Elsewhere in this pamphlet we have included sample forms as well as resources where you can find more information and other types of advance directive forms.

Can I change my mind after I write an advance directive?

Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you can also change an advance directive by oral statement; physical destruction of the advance directive; or by writing a new advance directive.

If your driver's license or state identification card indicates you are an organ donor, but you no longer want this designation, contact the nearest driver's license office to cancel the donor designation and a new license or card will be issued to you.

What if I have filled out an advance directive in another state and need treatment in Florida?

An advance directive completed in another state, as described in that state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

- If you designate a health care surrogate and an alternate surrogate be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.
- Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.
- Set up a file where you can keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.
- Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.
- If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, or the significant persons in your life.

More Information On Health Care Advance Directives

Before making a decision about advance directives you might want to consider additional options and other sources of information, including the following:

- As an alternative to a health care surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name

another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information or read Chapter 709, Florida Statutes.

If you choose someone as your durable power of attorney be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.

- If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest. The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, health care provider, or an ambulance service may also have copies available for your use. You, or your legal representative, and your physician sign the DNRO form. More information is available on the **DOH** website or **www.MyFlorida.com** (type DNRO in these website search engines) or call (850) 245-4440.

  When you are admitted to a hospital the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.
- If a person chooses to donate, after death, his or her body for medical training and research the donation will be coordinated by the Anatomical Board of the State of Florida. You, or your survivors, must arrange with a local funeral home, and pay, for a preliminary embalming and transportation of the body to the Anatomical Board located in Gainesville, Florida. After being used for medical education or research, the body will ordinarily be cremated. The cremains will be returned to the loved ones, if requested at the time of donation, or the Anatomical Board will spread the cremains over the Gulf of Mexico. For further information contact the Anatomical Board of the State of Florida at (800) 628-2594 or **www.med.ufl.edu/anatbd**.
- If you would like to learn more on organ and tissue donation, please visit the Joshua Abbott Organ and Tissue Donor Registry at **www.DonateLifeFlorida.org** where you can become organ, tissue and eye donors online. If you have further questions about organ and tissue donation you may want to talk to your health care provider.
- Various organizations also make advance directive forms available. One such document is "Five Wishes" that includes a living will and a health care surrogate designation. "Five Wishes" gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication, and other details that might bring you comfort such as what kind of music you might like to hear, among other things. You can find out more at:

  Aging with Dignity
  www.AgingWithDignity.org

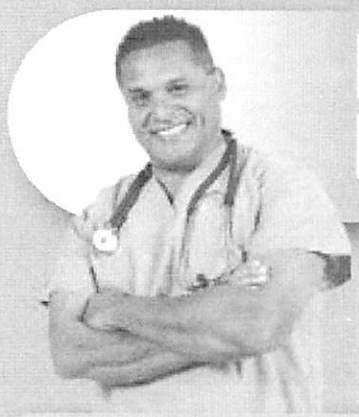
(888) 594-7437

Other resources include:

American Association of Retired Persons (AARP)
www.aarp.org
(Type "advance directives" in the website's search engine)

Your local hospital, nursing home, hospice, home health agency, and your attorney or health care provider may be able to assist you with forms or further information.

Brochure: End of Life Issues
www.FloridaHealthFinder.gov
(888) 419-3456



Privacy and Your Health Information

Your Privacy Is Important to All of Us

Most of us feel that our health and medical information is private and should be protected, and we want to know who has this information. Now, Federal law

- Gives you rights over your health information
- Sets rules and limits on who can look at and receive your health information

Your Health Information Is Protected By Federal Law

Who must follow this law?

- Most doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health care providers
- Health insurance companies, HMOs, most employer group health plans
- Certain government programs that pay for health care, such as Medicare and Medicaid

What information is protected?

- Information your doctors, nurses, and other health care providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow this law

The Law Gives You Rights Over Your Health Information

Providers and health insurers who are required to follow this law must comply with your right to

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes
- If you believe your rights are being denied or your health information isn't being protected, you can
  - File a complaint with your provider or health insurer
  - File a complaint with the U.S. Government

You should get to know these important rights, which help you protect your health information. You can ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint, from the website at www.hhs.gov/ocr/hipaa/

PRIVACY

The Law Sets Rules and Limits on Who Can Look At and Receive Your Information

To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared

- For your treatment and care coordination
- To pay doctors and hospitals for your health care and help run their businesses
- With your family, relatives, friends or others you identify who are involved with your health care or your health care bills, unless you object
- To make sure doctors give good care and nursing homes are clean and safe
- To protect the public's health, such as by reporting when the flu is in your area
- To make required reports to the police, such as reporting gunshot wounds

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot

- Give your information to your employer
- Use or share your information for marketing or advertising purposes
- Share private notes about your mental health counseling sessions

For More Information

This is a brief summary of your rights and protections under the federal health information privacy law. You can learn more about health information privacy and your rights in a fact sheet called *"Your Health Information Privacy Rights."* You can get this from the website at www.hhs.gov/ocr/hipaa/.

Other privacy rights
Another law provides additional privacy protections to patients of alcohol and drug treatment programs. For more information, go to the website at www.samhsa.gov.

Published by:

U.S. Department of Health & Human Services Office for Civil Rights

The Law Protects the Privacy of Your Health Information

Providers and health insurers who are required to follow this law must keep your information private by

- Teaching the people who work for them how your information may and may not be used and shared
- Taking appropriate and reasonable steps to keep your health information secure

1564 Kingsley Avenue
Orange Park, FL 32073

Insurance Company Payment Policy

I have been advised that Clay Surgery Center will bill my insurance company directly for my procedure(s). I have been further advised that the payment may be sent to me by my insurance company. By signing below, I affirm and attest that I am in no way entitled to this reimbursement for my procedures, and I understand that this money is intended to pay the above mentioned companies and physicians.

Accordingly, it is hereby understood and agreed that I have no right, implied or otherwise, to said funds, as they do not belong to me, and/or the insured party, and are intended to pay for my care and procedure(s) which are being performed with my informed consent.

Furthermore, in the event that I receive a check(s) from the responsible insurance company as payment for my procedure(s) or the insured's procedure(s) I will immediately, or within 48 hours, contact Clay Surgery Center about the check, and return these funds to the appropriate party. I understand that I am ultimately responsible for all medical bills if my insurance company fails to pay, and I will assist Clay Surgery Center and any entity with collection of any funds.

In the event that a check or checks are made payable to me or the insured, and is/are received by the facility, I hereby grant the facility the express permission, and a limited power of attorney solely and exclusively for the purpose of endorsing said checks which will obviate the necessity of returning to the facility with the express intent of endorsing said checks to the facility.

If either part defaults in the performance of any of the terms, provisions, covenants and conditions and by reason thereof, the other part employees the services of an attorney to enforce performance of the covenants, or to perform any service based upon defaults, regardless of the initiation of court proceedings, then in any of said events, the prevailing party shall be entitled to recover from the non-prevailing party, all of the prevailing party's reasonable attorney's fees and all expenses and costs incurred by the prevailing party pertaining thereto (including costs and fees relating to any appeal) and in the enforcement of any remedy. By signing below, I agree that the sole and exclusive venue for any litigation arising from or related to this agreement shall be in the Court of Clay County.

_____ _____

Signature Date

1564 Kingsley Avenue / Orange Park, FL 32073

Phone: 904.264.0400 / Fax: 904.264.0401

www.claysurgery.com

ASSIGNMENT OF BENEFITS FORM

Financial Responsibility:

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurances and any other health/medical plan, to issue payment check(s) directly to **Clay Surgery Center or authorized billing agent** for the services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information:

I hereby give **Clay Surgery Center or authorized billing agent** to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my insurance signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **Clay Surgery Center** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date