2807-2 Capital Medical Boulevard • Tallahassee, FL 32308 • Phone (850) 402-4107 • Fax (850) 402-4108

Last Name _____ First Name _____ MI _____

Address _____ Apt.# _____ City _____

State _____ Zip _____ Home # _____ Cell # _____

Date of Birth _____ Social Security # _____ Sex _____

Occupation _____

Marital Status _____ Race _____ Other Contact # _____

Employer _____ Phone _____

Address _____

Name of Spouse or Next of Kin _____ Relationship _____

Address _____ Zip _____ Phone _____

Employer _____

Address _____ Phone _____

Name of Primary Insurance Provider _____

Address _____ Phone _____

City _____ State _____ Zip _____

Contract Number _____ Group Number _____

Subscriber's Name _____ Sex _____

Birth Date _____ Relationship to Patient _____

Subscriber's Social Security Number _____

Effective Date _____ Benefits Phone _____

Employer _____

Address/Phone _____

Name of Secondary Insurance Provider _____

Address _____ Phone _____

City _____ State _____ Zip _____

Contract Number _____ Group Number _____

Subscriber's Name _____ Sex _____

Birth Date _____ Relationship to Patient _____

Subscriber's Social Security Number _____

Effective Date _____ Benefits Phone _____

Employer _____

Address/Phone _____

2807-2 Capital Medical Boulevard • Tallahassee, FL 32308 • Phone (850) 402-4107 • Fax (850) 402-4108

WE MUST HAVE COPIES OF YOUR INSURANCE CARDS.

MANY INSURANCE COMPANIES REQUEST A COPY OF THE I.D. CARD BEFORE THEY WILL PAY A CLAIM.

PLEASE BE PATIENT IF WE ASK TO SEE YOUR CARD FREQUENTLY.

WE CANNOT HELP YOU GET YOUR MEDICAL BILLS PAID UNTIL WE SATISFY THE INSURANCE COMPANIES.

If you have a third insurance provider, please give a copy of the insurance card to the receptionist.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize insurance benefits directly payable to ***Capital City Surgical Center***. I understand that I am responsible for any amounts not paid by my insurance companies.

RELEASE OF INFORMATION:

I authorize ***Capital City Surgical Center*** to release any information requested by my insurance company to insure prompt, accurate payment of my claims.

I certify the information furnished here is correct to the best of my knowledge.

Date: _____

Patient's Signature: _____

Signature of Insured: _____

PATIENT HISTORY

Patient Name:_____ DOB:_____

Referring Physician: _____

Name and Number of Ride Home: _____

Reason for Procedure: _____

_____

Do you drink alcohol: ☐ Yes ☐ No If yes, how much?_____How often?_____

Smoke: ☐ Yes ☐ No If yes, how much?_____

Recreational Drugs: ☐ Yes ☐ No If yes, what type?_____

How often? _____

Exercise? ☐ Yes ☐ No If yes, how much?_____

For females, date of LMP? _____ Is there a chance you could be pregnant? ☐ Yes ☐ No

Please list past and present medical problems: _____

_____

_____

Do you need to take an antibiotic before having any procedures? ☐ Yes ☐ No

If yes, please list why. _____

_____

What type of surgeries have you had? _____

_____

What type of medications do you take? (OTC and/or prescriptions) Please list doses and how often you take this medication. _____

_____

_____

Please list all allergies to medications and foods that you have. What happens when you come in contact with anything that you have listed? _____

_____

_____

Do you have a latex allergy? ☐ Yes ☐ No If yes, what happens?_____

Please list any family medical history including relationship of relative: _____

_____

How tall are you?_____How much do you weigh?_____

What prep, if any, did you take for the procedure you are having?

☐ Suprep
☐ Magnesium Citrate
☐ Dulcolax Tablets
☐ Trilytlely
☐ Golytely
☐ Nulytely

Capital City Surgical Center

2807-2 Capital Medical Boulevard • Tallahassee, FL 32308 • Phone (850) 402-4107 • Fax (850) 402-4108

Acknowledgement Form

As a patient choosing Capital City Surgical Center for my procedure, at the time of scheduling, I was informed both verbally and in writing that:

- I have rights and responsibilities as a patient.
- as part of my rights, I have the right to privacy. The staff will consider protecting my privacy by pulling curtains in patient care areas, limiting the posting of my name and refraining from discussing my health information with individuals unless I have granted permission.
- the contact information for filing grievances.
- the physician who is rendering services has an ownership interest in the above referenced facility. The physician has given me the option to be treated at another facility, which I have declined. I acknowledge that I can receive additional information related to potential conflicts of interest for those who provide care, services, as well as governance, upon request.
- the center does not honor Advance Directives/Living Wills at the facility. Should you require transport to another facility, they will be notified of your wishes.

  Do you have an Advance Directive? ☐ Yes ☐ No _____ (patient initials)

  If NO above, the patient was offered information by staff member _____ (staff initials)

I was informed both verbally and in writing of the above information prior to my scheduled procedure. ☐ Yes ☐ No

If NO, the information has been reviewed on the day of my procedure both verbally and in writing. I have been given the option to continue care at Capital City Surgical Center or have my appointment rescheduled at another facility the same day. _____ (patient initials)

_____ / _____ / _____

Patient Signature | Date | Witness/Staff Signature

_____ / _____ / _____

Signature of Guardian/Responsible Party | Date | Relationship to Patient

2807-2 Capital Medical Boulevard • Tallahassee, FL 32308 • Phone (850) 402-4107 • Fax (850) 402-4108

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who might be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care options. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide to such restrictions.

Patient Name: _____

Patient's Representative: _____

Relationship to Patient: _____

Signature: _____

Date: _____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

Capital City Surgical Center

2807-2 Capital Medical Boulevard • Tallahassee, FL 32308 • Phone (850) 402-4107 • Fax (850) 402-4108

HIPAA 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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example, your protected health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information needed to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment, and inform you of treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the option to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, worker's compensation, inmate, and other required uses and disclosures: Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) - Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, protected health information that is restricted by law, information that is related to medical research in which you agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information - This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications - You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agreed to accept this notice alternatively, i.e. electronically.

You may have the right to request an amendment to your protected health information - If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures - You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to be notified in the event of a breach - We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically.

We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgement" form. Please note that by signing the Acknowledgement form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Please contact us for more information:

Tammy Smith, Privacy Officer
Capital City Surgical Center
2807-2 Capital Medical Blvd
Tallahassee, FL 32308
(850) 402-4107

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
1-800-696-6775