Park Place Surgery Center

Patient Guide

It is our pleasure to welcome you to Park Place Surgery Center (PPSC). We are grateful for the privilege of caring for and serving you. We hope you find this guide helpful in preparing for your time at our facility.

Park Place Surgery Center (PPSC) is a multi-specialty ambulatory surgery center (ASC) that provides patients with a safe, cost-effective alternative to a hospital environment for a variety of procedures. We are committed to providing you with the highest standard of care which is why our facility is both Medicare certified and AAAHC accredited. The facility is open at 6 a.m. and performs procedures daily (Monday through Saturday) until 5 p.m. Our outpatient facility has 2 Operating Rooms and 1 Procedure Room. We encourage all patients to participate in their care, ask questions, and alert their physician or another healthcare professional if they have any questions concerning their treatment. We work hard to maintain our surgical schedule and appreciate your patience if there is an unavoidable delay.

At Park Place Surgery Center, you will have your procedure and be driven home to recover the same day. You will be asked to bring a responsible adult who will take you home and make arrangements for a responsible adult to stay with you for the first 24 hours of your recovery.

Lower prices, Medicare certified and AAHC accredited.

We have compiled the following forms to expedite your registration at our facility. We ask that you please completely fill out the enclosed forms and bring them with you on the day of your scheduled procedure.

PPSC charges a facility fee for each procedure. It does not include fees for your surgeon, consulting physician, anesthesiologist or pathologist.

Before your visit…

You will receive 1-2 phone calls from us detailing the following:

* Notification of any financial responsibility due at time of service.
* Arrival time for your procedure.
* Pre-operative interview.

During your visit…

Efficient Care

You will be cared for by our exceptional team of nurses, anesthesiologists and support staff. We will make every effort to ensure your utmost comfort during your time at our facility. Our goal is to keep you informed and reassured throughout the duration of your procedure.

After your visit…

After your procedure, you will be moved to our comforting Recovery Area.

The length of your stay post-operatively varies accordingly to the type of procedure and your surgeon's instructions. While in our Recovery Area, your surgeon will speak to both you and your family members for important discharge information and care. After careful monitoring for the appropriate time, you will be discharged to a responsible adult to accompany you home.

Park Place SURGERYCenter

www.parkplacesurgerycenter.com

"Our mission at Park Place Surgery Center is to provide comforting, quality, cost-effective healthcare services that exceed your expectations. Our goal is to create a positive healing environment for our patients that focuses on individualized care."

Park Place Surgery Center
2450 Maitland Center Parkway
Suite 100
Maitland, FL 32751
Phone: 407.875.0296 * Fax: 407.875.0929

Park Place Surgery Center

Patient Information

SURGERY Partners

Compassion

Care

Expertise

WHAT WE ARE: an outpatient surgical and procedure facility licensed by the State of Florida.

WHO WE ARE: owned by physicians who developed the surgery center to provide a safe and comfortable medical facility that would provide efficient and effective service to patients.

WHY WE WERE OPENED: outpatient care has been proven to increase patient comfort through personalized care while delivering quality services. Physicians joined together to open a facility to provide this personalized attention and quality services to their patients.

YOUR RIGHTS AS A PATIENT: you have the right to choose the provider and the facility for your health care services. You will not be treated differently by your physician if you choose to obtain health care services at another facility.

YOUR CHOICE: please discuss with your physician your questions or concerns if you may want to have your procedure at an alternative health facility.

CREDENTIALS: all physicians have been credentialed according to AAAHC standards. Information is available upon request.

PATIENT GRIEVANCES: if patients have complaints or concerns in regard to their care at PPSC, they are encouraged to fill out a grievance form, which is available upon request at the front desk. The Clinical Administrator or designee will be available to speak to you upon request.

MALPRACTICE INSURANCE: your physician may or may not have malpractice insurance but has satisfied the state requirements for this election.

ADVANCE DIRECTIVES: if you have an advance directive or living will, the surgery center will still transfer you to the closest hospital whom will make decisions about following any advance directive or living will. You have a right to have your living will present in your medical record at the Center and you have a right to the Center's policy prior to your date of surgery. Please go to www.parkplacesurgerycenter.com to view your Patient Rights and Advance Directive Policy. AHCA Advance Directive form can be found at: http://www.fdhc.state.fl.us/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/index.shtml.

AHCA Consumer Complaint, Publication and Information Call Center

The agency provides a toll-free telephone system for consumers to call in order to file complaints, receive publications, information and referral numbers. This system can be accessed by calling the number below between the hours of 8:00 A.M. and 6:00 P.M. Eastern Time Monday thru Friday. **Complaints about health care facilities are taken during regular business hours, 8:00 A.M. to 5:00 P.M., Eastern Standard Time (EST) (888) 419-3456. Complaints in regard to Medicare are addressed on the Office of the Medicare Beneficiary Ombudsman Web site: www.cms.hhs.gov/center/ombudsman.asp.**

www.parkplacesurgerycenter.com

THANK YOU FOR CONSIDERING RECEIVING HEALTH CARE SERVICES AT PARK PLACE SURGERY CENTER.

Park Place Surgery Center
2450 Maitland Center Parkway
Suite 100
Maitland, FL 32751
Phone: 407.875.0296 * Fax: 407.875.0929

Surgery Center Admission

LEGAL RELATIONSHIP BETWEEN SURGERY CENTER AND PHYSICIANS: I understand that all physicians furnishing services to the patient, including the patient's physician, and any specialist such as an anesthesia provider, radiologist, or pathologist are independent contractors with the patient and are not employees or agents of the surgery center. The patient is under the care and supervision of his/her physician and it is the responsibility of the surgery center and its staff to carry out instructions of the physician. It is the responsibility of the patient's physician to obtain the patient's informed consent, to medical or surgical treatment or procedures. Any questions concerning the nature or results of any examination or treatment should be directed to the patient's physician and not to the surgery center employees.

OTHER PROFESSIONAL SERVICES: I understand that my physician may have a professional radiology service review radiological images. My physician may also send specimens to a professional pathology laboratory for a pathological diagnosis. Radiology and pathology services are billed separately by those individual physicians and laboratories.

PERSONAL VALUABLES: It is agreed and understood that the surgery center shall not be responsible for any personal property brought by patient to the surgery center, including but not limited to, money, jewelry, documents, or any other articles.

OWNERSHIP OF SURGERY CENTER: I have been informed there are physicians who have ownership in this surgery center. I understand that I am free to choose another facility in which to receive services.

ADVANCE DIRECTIVE/LIVING WILL: I understand that if an emergency medical condition should occur, I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advance directive or living will, the surgery center will still transfer me to a hospital which will make decisions about following any advance directives or living will. If I should be transferred to a hospital, I consent to the hospital to release copies of my medical records to the surgery center to review the episode of care. I have the following:

	Copy given to Surgery Center:
____ Living Will	_____
____ Health care surrogate, proxy, or durable power of attorney	_____
____ Power of Attorney	_____

PATIENT PRIVACY, RIGHTS AND RESPONSIBILITIES: I have been offered a copy of the Privacy Notice. I received a copy of the patient rights and responsibilities statement. I know to whom I can express suggestions or complaints.

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 Center's 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 Center for all such services, at the Center's regular rates and terms should my insurance company deny payment. I shall also be responsible for any deductibles or co-payments owed at the time of services. I am responsible for payment within 60 days of the date of the service provided unless there is a contact the surgery center has signed with my insurer that states otherwise. Should this account be referred for collection to any attorney or collection agency, I shall pay all attorney's fees and collections 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 law. I hereby certify that the information given by me in applying for payment under Titles XVIII and XIX of the Society Security Act or by any other payer is correct. I assign to the Surgery Center all benefits due me under the terms of said policies and programs but not to exceed the Center's regular charges for similar services. **I authorize payment of medical benefits to the surgery center for the services provided.**

I hereby acknowledge the above statements.

_____ _____

Patient Date Time Witness Date Time

(In the event the patient is a minor, unconscious, or is otherwise not competent to acknowledge an understanding due to physician or mental condition, complete the following).
If patient's personal representative, state relationship and authority:

_____ _____

Patient's Representative Date Time Witness Date Time

I also acknowledge that I have received the following items **prior to the date of this procedure**:

____ Patients Rights and Responsibilities
____ The surgery center's policy about advance directives
____ Physician ownership information

Park Place SURGERYCenter

Patient Label

Pre-Anesthesia Assessment

The amount of medication given to you during your procedure is adjusted according to your height and weight.

Current: Height _____ Weight _____ Age _____

Have you had surgery before? _____ Yes _____ No If so, when and what kind of surgery? _____

_____

Have you or any members of your family (blood relatives) had problems, INCLUDING FEVER, with prior anesthetics?

_____ Yes _____ No If yes, explain: _____

_____

Have you had any drug reactions or drug allergies? _____ Yes _____ No _____ SEE MEDICATION/ALLERGY LIST

Circle if you have any of the following allergies:

Latex Iodine/Betadine Seafood/Shellfish Morphine/Demerol Sulfa/Eggs IVP dye

Do you have or have you had any of the following?	Yes	No	If yes, give additional information.
A. Thyroid or goiter problems			
B. Diabetes or hypoglycemia			
C. Epilepsy or seizures			
D. High blood pressure or stroke			
E. Heart disease or mitral valve prolapse			
F. Chest pain or angina (pacemaker/defib.)			
G. Lung disease or emphysema			
H. Chronic cough, asthma, or shortness of breath			
I. Hepatitis, cirrhosis, or jaundice			
J. Kidney disease			
K. Ulcers or hiatal hernia			
L. Anemia or sickle cell disease			
M. Recent weight loss			

Are you now or have you ever been in a drug recovery program? _____ Yes _____ No

Do you drink more than 2 alcoholic beverages daily? _____ Yes _____ No If so, how many? _____

Do you smoke? _____ Yes _____ No If yes, _____packs per day for _____years.

Park Place SURGERYCenter

Patient Label

Pre-Anesthesia Assessment (continued…)

	Yes	No	If yes, give additional information.
Have you had broken facial bones?			
Have you had back, jaw, or nose surgery?			
Do you use eye drops or wear contact lenses?			
Do you have loose teeth, caps, crowns, or dentures?			
Have you had an abnormal chest film or EKG?			
Do you have back trouble?			
Are you pregnant? If not, when was your last period?			
Have you had a blood transfusion?			
Do you take blood-thinning medications?			

Have you ever been diagnosed or told you are positive for HIV (virus that causes AIDS)? _____ Yes _____ No

Do you have any other illness or medical condition not mentioned above (e.e. cancer, neurological, etc.)? ____ Yes ____ No

Do you presently take any medication? If so, List the medication you take and the amount and frequency:

_____

_____

_____

_____

Do you take vitamins, herbal medications, or herbal drinks? If so, please list:

_____

_____

Patient's or guardian's signature _____ Date: _____

Pre-admission screening nurse: _____ Date: _____
BRAD Received: Yes or No (please circle one)
DPOA: Yes or No (please circle one)

Anesthesia Care Provider's (ACP) ASA: See Anesthesia Record
Respiratory: Bilaterally clear ___ Yes ___ No ____ Other _____
Cardiac: Regular Rate & Rhythm, No Significant Murmur ___ Yes ___ No ___ Other _____
_____
Anesthesia Care Provider's Signature: _____ Date: _____
I have reviewed the anesthesia-related and procedural risks on this patient for this procedure and determined that the patient is an ASC candidate.

_____ _____ _____
Supervising physician signature if indicated Date Time

Park Place SURGERYCenter

Patient Label

Use or Disclosure Authorization

I, _____, hereby authorize **Park Place Surgery Center, LLC** (ENTITY) to use or disclose the following protected health information:
(Specifically describe the information to be used or disclosed, including meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

_____
_____
_____
_____
_____

The protected health information may be disclosed to: ***(Insert name of person or entity who may receive the information).***

_____

This protected health information is being used or disclosed for the following purposes: *(List specific purposes here. The patient may indicate that the information to be disclosed is "at the patient's request" if the patient does not choose to provide an explanation of the purpose of this request).*

_____
_____
_____

I understand that, as set forth in the ENTITY's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Privacy Officer
Park Place Surgery Center, LLC
2450 Maitland Center Parkway, Suite 100
Maitland, FL 32751

I understand that a revocation is not effective to the extent that the ENTITY has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that the ENTITY will not condition my treatment on whether I provide authorization for the requested use or disclosure.

Park Place SURGERYCenter

Patient Label

Use or Disclosure Authorization (continued)…

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

(A copy of the signed authorization should be provided to the patient. If this authorization is being requested by the ENTITY for its own purposes, the ENTITY must provide the patient with a copy of the signed authorization).

Park Place Surgery Center, LLC (ENTITY)

Disclosure Authorization for Information Requests

[NOTE: This is the form to use for patient's authorization to obtain information from other health care providers.]

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I, _____, hereby authorize the following providers: ***(list all providers from whom information is being sought)***

_____

_____

_____

to disclose the following protected health information to Park Place Surgery Center, LLC. *(check as applicable)*

____ Copies of EKGs taken within the past 5 years.
____ Medical history, including specific progress notes regarding any problems that would impact my surgery or procedure's progress or outcome.
____ A list of allergies.
____ Results of relevant diagnostic or laboratory tests.
____ Other _____

This protected health information is being used by the facility for the purpose of preparation for an outpatient procedure at the Park Place Surgery Center, LLC.

I understand that, as set forth in the ENTITY's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Privacy Officer
Park Place Surgery Center, LLC
2450 Maitland Center Parkway, Suite 100
Maitland, FL 32751

I understand that a revocation is not effective to the extent that the ENTITY has relied on the use or disclosure of the protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that the ENTITY will not condition my treatment on whether I provide authorization for the requested use or disclosure.
I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent that the state law provides greater access rights).
- Refuse to sign this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

(A copy of the signed authorization must be provided to the patient).

Park Place SURGERY Center

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or further physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information

The ENTITY may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the ENTITY has obtained your authorization or the use of disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. **Treatment:** We will use and disclose your potted 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 treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the ENTITY with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. **Payment:** Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

C. **Operations:** We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of all or a portion of the ENTITY and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities; employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. **Other Uses and Disclosures:** As part of treatment, payment and health care operations, we may also disclose your protected health information for the following purposes:

1. To remind you of your surgery date.
2. We may, from time to time, contact you to provide information about treatment alternatives or other health-related benefits and services that we provide and that may be of interest to you.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. **When Legally Required or Permitted:** We will disclose your protected health information when we are required or permitted to do so by any federal, state, or local law. One situation in which we may disclose your protected health information is in the instance of a breach involving your protected health information, to notify you, law enforcement and regulatory authorities, as necessary, of the situation, and others as appropriate to resolve the situation.

Privacy Notice (continued…)

B. **When There Are Risks to Public Health: We may disclose your protected health information for the following public activities and purposes:**

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. **To Report Suspected Abuse, Neglect or Domestic Violence:** We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. **To Conduct Health Oversight Activities:** We may disclose your protected health information to a health oversight agency for activities including audits, civil, administrative, or criminal investigations, proceedings, or actions, inspections, licensure or disciplinary actions, or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. **In Connection with Judicial and Administrative Proceedings:** We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. **For Law Enforcement Purposes:** We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physician injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the ENTITY has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. **To Coroners, Funeral Directors, and for Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Once you have been dead for 50 years (or such other period as specified by law), we may use and disclose your health information without regard to the restrictions set forth in this notice. Protected health information may be used and disclosed for cadaveric organ eye or tissue donation purposes.

H. **For Research Purposes:** We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information. Under certain circumstances, your information my also be disclosed without your authorization to researchers preparing to conduct a research project or for research on decedents or to researchers pursuant to a written data user agreement.

I. **In the Event of a Serious Threat to Health or Safety:** We may, consistent with applicable law and ethical standards of conduct,use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. **For Specified Government Functions:** In certain circumstances, federal regulations authorize the ENTITY to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical stability determinations, correctional institutions, and law enforcement custodial situations.

K. **For Worker's Compensation:** The ENTITY may release your health information to comply with worker's compensation laws or similar programs.

L. **Business Associates:** We may contract with one or more business associates through the course of our operations. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. We require that our business associates sign a business associate agreement and agree to safeguard the privacy and security of your health information.

Privacy Notice (continued…)

III. Use and Disclosures Permitted without Authorization but with Opportunity to Object
We may disclose your protected health information to your family member, or a close personal friend, if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures, or we can infer from the circumstances that you do not object, or we determine in the exercise of our professional judgement, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which you Authorize:
Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization, in writing, at any time except to the extent that we have taken action in reliance upon the authorization. Examples of disclosures that require your authorization are:

A. **Marketing:** Except as otherwise permitted by law, we will not use or disclose your health information for marketing purposes without your written authorization. However, in order to better serve you, we may communicate with you about refill reminders and alternative products. Should you inquire about a particular product-specific good or service, we may also provide you with information materials. We may also, at times, send you informational materials about a particular product or service that may be helpful for your treatment.

B. **No Sale of Your Health Information:** We will not sell your health information to a third party without your prior written authorization.

V. Your Rights
You have the following rights regarding your health information:

A. **The right to inspect and copy your protected health information:** You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your surgeon and the ENTITY use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for the use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgement, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Please contact our Privacy Officer if you have questions about access to your medical record.

B. **The right to request a restriction on uses and disclosures of your protected health information:** You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

If you request that the ENTITY not disclose your protected health information to your health plan for the purposes of payment or healthcare operations (but not treatment), and if you are paying for your treatment out-of-pocket in full, then the ENTITY must honor your requested restriction. Otherwise, the ENTITY is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the ENTITY does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

Privacy Notice (continued…)

C. **The right to request to receive confidential communications from us by alternative means or at an alternative location:** You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specifications of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. **The right to request amendments to your protected health information:** You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Request for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendment.

E. **The right to receive an accounting:** You have the right to request an accounting of certain disclosures of your protected health information made by the ENTITY. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for an ENTITY directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. After January 1, 2014 (or a later date as permitted by HIPAA), the list of disclosures will include disclosures made for treatment, payment or health care operations using our electronic health record (if we have one for you). We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. **The right to obtain a paper copy of this notice:** Upon, request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. Our Duties

The ENTITY is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the ENTITY changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact at your next visit. In the event there has been a breach of your secured protected health information, we will notify you.

VII. Complaints

You have the right to express complaints to the ENTITY and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the ENTITY by contacting the ENTITY's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be related against in any way for filing a complaint.

VIII. Contact Person

The ENTITY's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by the ENTITY you may submit a complaint to our Privacy Officer by sending it to:

Privacy Officer
Park Place Surgery Center
2450 Maitland Center Parkway, Suite 100
Maitland, FL 32751

The Privacy Officer can be contacted by telephone at 407-875-0296.

IX. Effective Date

This Notice is effective April 14, 2003, with revisions effective February 17, 2010 and September 2013.

Park Place Surgery Center, LLC (ENTITY)

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have received the attached Privacy Notice.

_____ _____

Patient or Personal Representative Signature Date

_____

Patient Name

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____

_____

Patient's Statement of Rights and Responsibilities

The staff of this health care facility recognizes you have rights while a patient receiving medical care. In return, there are responsibilities for certain behavior on your part as the patient. This statement of rights and responsibilities is posted in our facility in at least one location that is used by all patients.

Your rights and responsibilities include:

A patient, patient representative or surrogate has the *right* to:

- Receive information about rights, patient conduct and responsibilities in a language and manner the patient, patient representative or surrogate can understand.
- Be treated with respect, consideration and dignity.
- Be provided appropriate personal privacy.
- Have disclosures and records treated confidentially and be given the opportunity to approve or refuse record release except when release is required by law.
- Be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- Receive care in a safe setting.
- Be free from all forms of abuse, neglect or harassment.
- Exercise his or her rights without being subject to discrimination or reprisal with impatient access to medical treatment or accommodations, regardless of race, national origin, religion, physical disability, or source of payment.
- Voice complaints and grievances, without reprisal.
- Be provided, to the degree known, complete information concerning diagnosis, evaluation, treatment and know who is providing services and who is responsible for the care. When the patient's medical condition makes it inadvisable or impossible, the information is provided to a person designated by the patient or to a legally authorized person.
- Exercise of rights and respect for property and persons, including the right to:
    - Voice grievances 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.
    - Have a person appointed under State law to act on the patient's behalf if the patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction. If a State court has not adjudged a patient incompetent, any legal representative designated by the patent in accordance with State law may exercise the patient's rights to the extent allowed by State law.
- Refuse treatment to extent permitted by law and be informed of medical consequences of this action.
- Know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.
- Have the right to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.
- A prompt and reasonable response to questions and requests.
- Know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care and know, upon request and prior to treatment, whether the facility accepts the Medicare assignment rate.
- Receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have charges explained.
- Formulate advance directives and to appoint a surrogate to make health care decisions on his/her behalf to the extent permitted by law and provide a copy to the facility for placement in his/her medical record.
- Know the facility policy on advance directives.
- Be informed of the names of physicians who have ownership in the facility.
- Have properly credentialed and qualified healthcare professionals providing patient care.

Patient's Statement of Rights and Responsibilities

A patient, patient representative or surrogate is *responsible for*:

- Providing a responsible adult to transport him/her home form the facility and remain with him/her for 24 hours, unless specifically exempted from this responsibility by his/her provider.
- Providing to the best of his or her knowledge, accurate and complete information about his/her health, present complaints, past illnesses, hospitalizations, any medications, including over-the-counter products and dietary supplements, any allergies or sensitivities, and other matters relating to his/her health.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Following the treatment plan recommended by his/her health care provider.
- Be respectful of all health providers and staff, as well as, other patients.
- Providing a copy of information that you desire us to know about a durable power of attorney, health care surrogate, or other advance directive.
- His/her actions if he/she refuses treatment or does not follow the health care provider's instructions.
- Reporting unexpected changes in his/her condition to the health care provider.
- Reporting to his/her health care provider whether he/she comprehends a contemplated course of action and what is expected of him/her.
- Keeping appointments.

COMPLAINTS:

Please contact us if you have a question or concern about your rights or responsibilities. You can ask any of our staff to help you contact the Administrative Director at the surgery center. Or, you can call 407-875-0296.

We want to provide you with excellent service, including answering your questions and responding to your concerns.

You may also choose to contact the licensing agency of the state:
Agency for Health Care Administration
2727 Mahan Drive, Tallahassee, FL 32308
1-888-419-3456

If you are covered by Medicare, you may choose to contact the Medicare Ombudsman at 1-800-MEDICARE (1-800-633-4227) or online at http://www.medicare.gov/claims-and-appeals/index.html. The role of the Medicare Beneficiary Ombudsman is to ensure that Medicare beneficiaries receive the information and help you need to understand your Medicare options and to apply your Medicare rights and protections.

Important Information

PATIENT SAFETY

Before your procedure…

If you have not been contacted 24 yours before your procedure, please call the facility for specific instructions.

Please notify your surgeon and the facility is there is any change in your physical condition such as cold and/ or fever.

The night before your procedure…

DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT.

Refrain from the use of mints, chewing gum or cigarettes. Failure to follow these instructions may result in the cancellation of your procedure.

Please do not take any medications after midnight unless instructed by your physician or our office.

You must arrange for a *responsible adult* to drive you home and to remain with you for the first 24 hours after your procedure.

The day of your procedure…

Wear loose, comfortable clothing that is big enough to accommodate any bandages after your procedure. Wear comfortable shoes such as slip-ons (no heels).

Do not wear any makeup or jewelry.

Do not bring any valuables with you.

Wearing contact lenses is not advised.

We provide containers for removable dentures and bridgework.

Females of child-bearing age will need to give a urine sample for pregnancy testing.

Do bring: your driver's license, insurance card(s), and any co-payment that may be due. Visa and Mastercard are accepted. Please no personal checks over $300.00.
Please limit the number of family/friends who come with you. Seating at PPSC is limited.

After your procedure…

Before you leave the facility, you will be given written instructions and pain prescriptions (if necessary) for your care at home.

If you are driving more than 30 minutes, put one or two pillows in your care so you can elevate the operative extremity.

Plan to rest the remainder of the day and expect to be drowsy for several hours after surgery.

A nurse from Park Place Surgery Center (PPSC) will phone you the day after your procedure to see how you are recovering and answer any questions/ concerns that you may have.

Please do not hesitate to call us at 407-875-0296 with any questions or concerns.

Park Place SURGERYCenter

REMINDER CARD

DATE OF PROCEDURE: _____

ARRIVAL TIME: _____

Park Place Surgery Center
2450 Maitland Center Parkway
Suite 100
Maitland, FL 32751
Phone: 407.875.0296 * Fax: 407.875.0929
www.parkplacesurgerycenter.com

Billing and Insurance

Thank you for choosing Park Place Surgery Center for your surgical procedure. We strive to make your experience a pleasant and efficient one. With that in mind, we like to inform our patients of their financial obligations prior to their procedure, so there are no surprises and/or misunderstandings.

Park Place Surgery Center collects any co-payments, un-met deductibles and co-insurance amounts on the day of your procedure. If you have any questions or concerns, please feel free to call or contact Medical Billing Solutions (MBS) at 1-866-631-7890. We encourage you to also contact your surgeon, anesthesia group and your insurance company if you have any questions about your financial obligations. You may be receiving a separate bill (other than from PPSC) from the following:

- Anesthesia Professional Services (APS)
- Pathology
- Durable Medical Equipment

Park Place SURGERYCenter

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2450 Maitland Center Parkway
Suite 100
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Frequently Asked Questions

Q. Why do I have to pay my deductible and co-insurance at the time of registration on the day of my procedure?

A. The policy of this facility, as with many health care facilities across the nation, is that patients pay their portion of co-insurance and any remaining deductible at the time of the procedure. This helps to keep the collection prices down; thus, the cost of doing business at a minimum. Ambulatory Surgery Centers are paid an average of 46% less than hospitals, on average for procedures; and thus, efficiency of care including collections, is extremely important.

Q. Why is the charge on the Explanation of Benefits (EOB) so high?

A. Historically, insurances that are contracted pay at a contracted rate—some pay a percentage of charges and self pay patients are billed at a minimum percentage of charges. The total amount is elevated because it is the norm and no one pays 100% of charges. Insurances, third party payers, Medicare and self-pay patients all pay at a negotiated rate. Traditionally, all payors/insurances and self-pay patients pay less to an Ambulatory Surgery Center than they pay to hospitals. Ambulatory Surgery Centers are well known for cost-efficient care.

Q. Why should I choose an ASC over a hospital?

A. Ambulatory Surgery Centers (ASCs), including Park Place Surgery Center, are known for their quality, value and convenience. ASCs are highly regulated to ensure quality care and patient safety. Choosing an ASC can save some patients up to 50% in out-of-pocket expenses. Since we only perform scheduled, non-emergent, outpatient procedures, ASCs operate extremely efficient.

Q. How long will I have to stay at the facility after my procedure (recovery period)?

A. Recovery periods vary from person to person and from procedure to procedure. A rule of thumb is that you can usually expect that longer procedures will require longer recovery periods and shorter procedures require shorter ones. The average recovery for patients at our facility is between thirty minutes to an hour and a half.

What happens behind the scenes of my procedure?

A. There are many people behind the scenes that perform various essential tasks that allow your time at our facility to be as efficient as possible. There are instrument technicians processing equipment, OR technicians pulling supplies and prepping your procedure room and front office staff that collects pertinent information necessary to process your insurance claim. Your medical chart is being reviewed by nurses and anesthesia providers to best prep for your care. The entire team at Park Place Surgery Center works towards the same goal—we want to EXCEED your expectations.

Why do I have to arrive at the facility one hour or more before my scheduled procedure?

A. There are two important reasons for this policy:

1. Sometimes physicians get ahead of schedule and it is important that the next patient be available and ready for their procedure.
2. Patients go through an assessment phase by nurses and anesthesiologists in preparation for their procedure. This takes time; and so that no patient feels rushed, it is important that all involved have time to make their contribution to your care.

THANK YOU FOR CONSIDERING RECEIVING HEALTH CARE SERVICES AT PARK PLACE SURGERY CENTER.

Park Place SURGERYCenter

Park Place Surgery Center
2450 Maitland Center Parkway
Suite 100
Maitland, FL 32751
Phone: 407.875.0296 * Fax: 407.875.0929
www.parkplacesurgerycenter.com

Directions to our facility

From Kissimmee/ Orlando:

Take ramp onto I-4E
Take Exit 90B to merge right onto W. Maitland Blvd.
Turn right at Lake Destiny Rd.
Turn left at Maitland Center Prky
Turn left at 2400 Maitland Center Prky
Turn right into 2450 Bldg.
PPSC is located on the 1st floor, Suite 100

From Lake Mary/ Sanford:

Take I-4 ramp towards Orlando
Take Exit 90 to merge right onto W. Maitland Blvd.
Turn right at Lake Destiny Rd.
Turn left at Maitland Center Prky
Turn left at 2400 Maitland Center Prky
Turn right into 2450 Bldg.
PPSC is located on the 1st floor, Suite 100

From East Orlando:

Merge onto the 408W
Take Exit for I-4E
Take Exit 90B to merge right onto W. Maitland Blvd.
Turn right at Lake Destiny Rd.
Turn left at Maitland Center Prky
Turn left at 2400 Maitland Center Prky
Turn right into 2450 Bldg.
PPSC is located on the 1st floor, Suite 100

From Clermont/ Ocoee:

Take Hwy 50 to FL Turnpike
Take ramp onto FL Turnpike South
Take Exit 265 to merge onto 408E towards Orlando/ Titusville
Take Exit 10B to merge onto I-4E toward Daytona Beach
Take Exit 90B to merge right onto W. Maitland Blvd.
Turn right at Lake Destiny Rd.
Turn left at Maitland Center Prky
Turn left at 2400 Maitland Center Prky
Turn right into 2450 Bldg.
PPSC is located on the 1st floor, Suite 100

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