

## NORTH TAMPA OUTPATIENT SURGICAL FACILITY ANESTHESIA EVALUATION

Surgical Procedure: _____				Age: _____		Ht.: _____		Wt.: _____						
PLACE AN "X" IN THE PROPER COLUMN:			YES	NO	DON'T KNOW	PLACE AN "X" IN THE PROPER COLUMN:			YES	NO	DON'T KNOW			
1. DO YOU HAVE TO TAKE ANTIBIOTICS TO PROTECT YOUR HEART BEFORE SURGERY?						11. HAVE YOU EVER HAD ANY DIGESTIVE TRACT PROBLEMS?								
2. DO YOU SMOKE? PPD _____ YRS. _____ QUIT _____						12. HAVE YOU EVER HAD ANY MUSCLE OR JOINT PROBLEMS?								
3. DO YOU USE RECREATIONAL DRUGS?						13. HAVE YOU EVER HAD ANY METABOLIC PROBLEMS?								
4. DO YOU DRINK ALCOHOL?						14. HAVE YOU EVER HAD A TIA OR CVA?								
5. DO YOU HAVE ANY LOOSE, CAPPED, OR FALSE TEETH?						15. HAVE YOU OR ANY FAMILY MEMBERS EVER HAD ANY PROBLEM WITH AN ANESTHETIC?								
6. DO YOU WEAR CONTACT LENSES?						16. ARE YOU PREGNANT?								
7. HAVE YOU EVER HAD ANY HEART PROBLEMS?	HIGH BLOOD PRESSURE					17. DO YOU HAVE ANY HISTORY OF ANY CANCERS? PLEASE LIST								
	LOW BLOOD PRESSURE					18. HAVE YOU EVER HAD ANY SURGERIES? PLEASE LIST								
	RHEUMATIC FEVER					19. DO YOU HAVE ANY ALLERGIES? PLEASE LIST								
	HEART ATTACK					PHYSICAL EXAMINATION / DOS			ASA#	1	2	3	4	5
	HEART MURMUR					AIRWAY								
	CHEST PAIN/ANGINA					HEART								
	IRREGULAR HEART BEAT					LUNGS								
8. HAVE YOU EVER HAD ANY LUNG PROBLEMS?						<input type="checkbox"/> LABS/EKG/CXR REVIEWED NPO _____ HRS. PROPOSED ANESTHESIA _____								
9. HAVE YOU EVER HAD ANY URINARY PROBLEMS?						PAIN MANAGEMENT /HEALTH STATUS UNCHANGED DATE _____ SIGNATURE _____								
10. DO YOU HAVE ANY INFECTIOUS DISEASES?						<input type="checkbox"/> PT REQUESTS ANESTHETIC SEDATION (MAC/GETA) <input type="checkbox"/> DR REQUESTS ANESTHESIA PRESENCE 2 <sup>o</sup> TO MEDICAL STATUS <input type="checkbox"/> PT & SURGEON REQUESTS POST-OP PAIN MANAGMENT <input type="checkbox"/> ANESTHESIA HAS REVIEWED EVALUATION WITH PATIENT & ADDRESSED CONCERNS								
HEPATITIS      HIV      TB      MRSA      (IF SO, PLEASE CIRCLE)						ANESTHESIOLOGIST'S SIGNATURE: _____ DATE _____								
PREGNANCY TEST _____						<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;">           PATIENT STICKER         </div>								
DATE: _____ BY: _____														
ACCU CHECK: _____ MG/DL (NORMAL RANGE 70 -- 110 MG/DL)														
DATE: _____ BY: _____														

**NORTH TAMPA OUTPATIENT SURGICAL FACILITY**  
**\*\*\*\* PLEASE PRINT CLEARLY & COMPLETE ALL INFORMATION \*\*\*\***

**PATIENT INFORMATION**

NAME: \_\_\_\_\_  
Last First MI

HOME PHONE: (\_\_\_\_) \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_  
Street Address Lot / Apt #

CELL PHONE: (\_\_\_\_) \_\_\_\_\_

SOCIAL SECURITY#: \_\_\_\_\_

PO Box \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ GENDER: M F

City State Zip

RACE: American Indian Asian / Pacific Black  
White Hispanic No response Other

OCCUPATION: \_\_\_\_\_

RELIGION: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_

MARITAL STATUS: S M D W

PRIMARY/FAMILY PHYSICIAN NAME: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION- PLEASE GIVE INSURANCE CARDS TO RECEPTIONIST**

**Relationship to Insured:** (please circle) SELF SPOUSE DEPENDENT OTHER \_\_\_\_\_

**Primary Insurance Co.** \_\_\_\_\_

Policy Holder (Insured): \_\_\_\_\_

Policy #/Member ID# \_\_\_\_\_

Group #: \_\_\_\_\_

**Secondary Insurance Co.** \_\_\_\_\_

Policy Holder (Insured): \_\_\_\_\_

Policy #/Member ID# \_\_\_\_\_

Group #: \_\_\_\_\_

**RESPONSIBLE PARTY - MUST BE FILLED OUT IF MINOR OR PATIENT IS NOT THE POLICY HOLDER**

NAME: \_\_\_\_\_  
Last First MI

PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_

SOCIAL SECURITY#: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

Is this a **Workman's Compensation** case: Yes No Date of Incident: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this an **Auto Accident** case: Yes No Date of Incident: \_\_\_\_/\_\_\_\_/\_\_\_\_

Adjuster's Name and Phone Number: \_\_\_\_\_

Is this due to **Other Injury / Accident** ? Yes No Date of Incident: \_\_\_\_/\_\_\_\_/\_\_\_\_

**NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU:** \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY:** \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

**MEDICARE SIGNATURE AUTHORIZATION**

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that this signature is a lifetime signature.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## PATIENT MEDICATION FORM

MEDICATION	DOSAGE	FREQUENCY	DATE

Date: \_\_\_\_\_ Preop RN: \_\_\_\_\_ PACU RN: \_\_\_\_\_  
 Last time medications were taken: \_\_\_\_\_  
 Medication changes/additions: \_\_\_\_\_  
 Medications taken today: \_\_\_\_\_

Date: \_\_\_\_\_ Preop RN: \_\_\_\_\_ PACU RN: \_\_\_\_\_  
 Last time medications were taken: \_\_\_\_\_  
 Medication changes/additions: \_\_\_\_\_  
 Medications taken today: \_\_\_\_\_

Date: \_\_\_\_\_ Preop RN: \_\_\_\_\_ PACU RN: \_\_\_\_\_  
 Last time medications were taken: \_\_\_\_\_  
 Medication changes/additions: \_\_\_\_\_  
 Medications taken today: \_\_\_\_\_

\*\* Please resume your medications as directed by your physician. Please do not resume or stop blood thinning medications (Aspirin, Vitamin E, Coumadin, Lovenox) unless directed by physician.

# North Tampa Outpatient Surgical Facility

## Notice of Rights and Responsibilities

### **Rights**

1. The right to quality care and treatment.
2. The right to know the identity and professional status of all individuals providing service to you.
3. The right to respectful safe care and treatment free from abuse and harassment.
4. The right to receive treatment regardless of race, color, sex, national origin, religion, handicap, disability, or sexual preference.
5. The right to exercise your rights without fear of reprisal.
6. The right to participate in decisions concerning care and treatment.
7. The right to be fully informed regarding one's condition.
8. The right to confidentiality of records and communications, and access to them.
9. The right to informative and personal privacy regarding your diagnosis, treatment options, and the potential outcomes of the treatment.
10. The right to understand and sign an Informed Consent form before receiving care.
11. The right to refuse a treatment, as permitted by law. You can refuse treatment and still receive alternate care.
12. The right to detailed information regarding service fees and charges.
13. The right to express spiritual and cultural beliefs.
14. The right to report a grievance.
15. The right to appropriate assessment and management of pain.
16. The right to know ASC rules that will affect your treatment.

### **Responsibilities**

1. You are responsible for providing accurate/complete information your health, for reporting perceived risks in your care, and for reporting unexpected changes in your health.
2. You are responsible for providing your healthcare insurance information to the ASC.
3. You are responsible for your actions if they refuse treatment or fail to follow your practitioner's instructions.
4. You are responsible for being respectful and considerate of other patients and organizational personnel.
5. You are responsible to ask questions if you do not understand the nature of your treatment.
6. You are responsible for your co-insurance, deductible and co-pay at the time of service. If there is a difference between the collected estimate and your actual responsibility, we will either refund your monies or send a statement for the balance. You have the right to receive an itemized bill for all services.
7. You are responsible to provide a responsible adult to transport you home from the facility and remain with you for 24 hours.

### **Disclosure of Ownership**

A Corporation formed by physicians owns this facility. Your physician may be an owner in or of this facility. Please be advised you have the right to choose where to receive services, including an entity which your physician may have a financial relationship.

These rights and responsibilities outlined the basic concepts of service here at the North Tampa Outpatient Surgical Facility. If you believe that at any time one or more of the statements has not been met during your care here, please ask to speak to the Medical Director or Center Director. We will make every attempt to understand your complaint/concern. We will correct the issue you have if it is within our control, and you will receive a written response.

# NORTH TAMPA OUTPATIENT SURGICAL FACILITY

## INFORMATION FOR OUTPATIENTS AND FAMILIES REGARDING ADVANCE DIRECTIVES

“Advance Directive” is a written or oral statement, which you complete in advance of serious illness, about how you want medical decisions made. An advance directive allows you to state your choices for health care or to name someone to make those choices for you if you become unable to make decisions about your medical treatment. There are two types of advance directives:

A **Living Will** generally states the kind of medical care you do or do not want if you become unable to make your own decision. It is called a “living will” because it takes effect while you are still living.

A **Durable Power of Attorney** for health care is a signed, dated, and witnessed paper naming another person, such as a husband, wife, daughter, son, or close friend as your “agent” or “proxy” to make medical decisions for you if you should become unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid.

You can find out more at:

Aging with Dignity  
[www.agingwithdignity.org](http://www.agingwithdignity.org)  
(888) 594-7437

American Association of Retired Persons (AARP)  
[www.aarp.org](http://www.aarp.org)  
(Type “advance directives” in the website’s search engine)

Partnership for Caring  
[www.partnershipforcaring.org](http://www.partnershipforcaring.org)  
(800) 989-9455

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.FloridaHealthStat.com](http://www.FloridaHealthStat.com)  
(Under Reports and Guides)  
(888) 419-3456

# NORTH TAMPA OUTPATIENT SURGERY

## PATIENT'S RIGHTS AND RESPONSIBILITIES

At North Tampa Outpatient Surgery, our patients are treated in a manner that recognizes their basic human rights.

**CARE:** You have the right to considerate, respectful care at all times and under all circumstances, with recognition of your personal dignity.

**PRIVACY:** You have the right, within the law, to personal and informative privacy.

**INFORMATION:** You have the right to be provided, to the degree known, information concerning your diagnosis, treatment and prognosis. When concern for a patient's health makes it inadvisable to give such information to the patient, such information is made available to an individual designated by the patient or to a legally authorized individual.

**SECURITY:** Disclosures and records are treated confidentially, and except when required by law, you have the right to approve or refuse the release of these records.

**PARTICIPATION:** Unless contraindicated by concerns for your health, you have the opportunity to participate in decisions involving your health care.

**ACCESS:** You shall be accorded impartial access to treatment regardless of race, color, sex, national origin, religion, handicap, disability or sexual preference. Tampa Outpatient Surgery adheres to all federal and state rules, regulations and policies to promote a non-discriminatory environment for all of our patients.

**BILLING:** *You are responsible for your co-insurance, deductible and co-pay at the time of service.* If there is a difference between the collected estimate and your actual responsibility, we will either refund your monies or send a statement for the balance. You have the right to receive an itemized bill for all services.

**IDENTIFICATION:** You have the right to know the identity and professional status of all individuals providing service to you.

**COMMENTS:** You are given the opportunity to report any comment concerning the quality of services provided to you during the time spent at the facility and to receive fair follow-up on your comments.

**DISCLOSURE OF OWNERSHIP:** A Corporation formed by physicians owns this facility. Your physician may be an owner in or of this Facility. Please be advised you have the right to choose where to receive services, including an entity in which your physician may have a financial relationship.

You received a copy of the Patient's Rights and Responsibilities prior to day of procedure:	YES	NO
You received a copy of information in regards to Advanced Directives prior to day of procedure	YES	NO

### PATIENT AND/OR FAMILY RESPONSIBILITIES INCLUDE:

- ❖ Any outcome that is the result of refusing treatment or not complying with treatment
- ❖ Providing your past and present medical/surgical history
- ❖ Understanding the nature of your surgery
- ❖ Following all treatment plans established for you
- ❖ Being considerate of other patients' rights
- ❖ Following the organization's rules and regulations governing patient care and conduct
- ❖ Providing feedback about service needs and expectations

- |   |     |    |
|---|-----|----|
| 1. Have you executed a Living Will                                    | YES | NO |
| 2. Have you executed a Durable Power of Attorney for decision-making? | YES | NO |

### If available please provide a copy of the document for your medical record

\*\*\*\*\*  
I recognize that I am requesting treatment by North Tampa Outpatient Surgical Facility and that I am responsible for any costs for that treatment, regardless of whether or not I have insurance coverage. I agree to promptly pay upon receipt, any statement for services rendered. Balances that remain unpaid after 30 days are subject to service charges not to exceed eighteen (18) percent per year. I further agree that if any amount remains outstanding for a period of sixty (60) days, that balance will be considered delinquent and may be turned over to a collection agency, or an attorney for collection. If the account is turned over to a collection agency or an attorney, because the account is delinquent, then and in that, I agree that in addition to the charge made by Tampa Outpatient Surgical Facility for medical services, I will also pay the charge made by the collection agency and/or reasonable attorney's fees and costs incurred collecting the unpaid balance of my account.

I hereby request and direct my insurance carrier to pay directly to North Tampa Outpatient Surgical Facility the medical benefit otherwise due to me under the terms of my policy. Payment of this amount as directed shall be the same as if paid by me. I also authorize the surgery center to release information (to include information regarding communicable or venereal diseases) acquired in the course of examination or treatment to my insurance company, peer review or hospital if transferred for follow-up care. A photocopy or similar copy of this assignment shall be as valid as if it were the original.

By my signature I certify that I, a patient/responsible party of a patient at North Tampa Outpatient Surgery have received a copy of my "Patient's Rights and Responsibilities, and the facility's Notice of Privacy Practices and have read and understand them thoroughly.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

Patient Sticker

*Gulf To Bay Anesthesiology Associates, P.A.*

*809 S. Albany Ave*

*Tampa, Fl 33606*

*(813) 258-3444*

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**Release of Medical Information and Payment Agreements**

Gulf To Bay Anesthesiology Associates, is a professional association, which provides anesthesia services as an independent contractor for North Tampa Outpatient Surgical.

Your anesthesia bill will be separate from the surgery center's bill and from your surgeon's bill. If you have any questions regarding our participation with your insurance company or any other billing questions, please contact us at the above phone number.

I authorize Gulf To Bay Anesthesiology Associates to release my medical records and other medical information as may be necessary to any person or corporation which may be liable for all or part of the charges for my medical care, including but not limited to my insurance company or companies, Medicare, Medicaid, worker's compensation carriers, or my employer. The release of such information shall be for the purpose of reimbursing Gulf To Bay Anesthesiology Associates for the medical services rendered to me.

The information to be released may include any medical records relating to treatment or diagnosis of alcohol or drug related illnesses, psychiatric or other mental care, eating disorders, or human immunodeficiency virus/AIDS test results.

I assign to Gulf To Bay Anesthesiology Associates my right to receive payment for any medical treatment provided to me by Gulf To Bay Anesthesiology Associates. I agree to make full payment for medical treatment provided by Gulf To Bay Anesthesiology Associates within 60 days and agree to pay all charges not covered by insurance or other payor, except as prohibited by law.

I understand that Gulf To Bay Anesthesiology Associates may bill and charge for services provided by my anesthesiologist and other members of the anesthesia care team. I hereby authorize payment directly to Gulf To Bay Anesthesiology Associates of benefits otherwise payable to me or my anesthesiologist and anesthesia care team members.

For self-pay patients:

I understand that any money paid prior to surgery is only an estimate. The estimate is based on the estimated length of the surgery. The exact charges cannot be determined in advance. If your surgery goes over the estimated length, you will be billed for the balance. If your surgery is under the estimated length, you will be issued a refund.

The consent is subject to revocation at any time except to the extent that Gulf To Bay Anesthesiology Associates has already taken action in reliance upon it. If not previously revoked, this consent will terminate when all payment transactions regarding my treatment have been completed.

If this form is signed by a Responsible party, the Responsible party attests that he or she is authorized to agree to the terms of this form on behalf of the patient, and so agrees, and the Responsible party accepts responsibility for payment of the patient's medical bills.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Responsible Party to patient