Suncoast Endoscopy of Sarasota
2089 Hawthorne Street, Suite 100, Sarasota, Florida 34239
Phone: (941) 952-1145 *Fax: (941) 952-1175*

ASSIGNMENT OF BENEFITS FORM

Assignment of Benefits:
I hereby assign all medical and procedure benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to Suncoast Endoscopy of Sarasota for medical 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.

Financial Responsibility:
All professional services rendered are charged to the patient and are due at the time of services, unless other arrangements have been made in advance with our practice financial counselor. Necessary forms will be completed to help expedite insurance carrier payments. However, YOU ARE responsible for all fees, regardless of insurance coverage. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law.

I have requested medical services from Suncoast Endoscopy of Sarasota 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 incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

The estimated facility charge for your procedure to be billed to your insurance company at Suncoast Endoscopy of Sarasota is:

Colonoscopy:	$1300.00 - $2400.00
Upper Endoscopy:	$1100.00 - $2200.00
Double Procedure:	$2200.00 - $3500.00
Flexible Sigmoidoscopy	$350.00 - $600

Authorization to Release Information:
I hereby authorize Suncoast Endoscopy of Sarasota to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing.

Disclosure of Physician Ownership Interest:

Your physician, _____, does/does not have a financial relationship with the center. You are entitled to obtain the services for which you have been referred to Suncoast Endoscopy of Sarasota at the location of your choice.

Alternative sources of the services for which you have been referred to this entity are as follows:

Sarasota Memorial Hospital
1700 S. Tamiami Trail
Sarasota, FL 34239

Doctors Hospital
5731 Bee Ridge Rd.
Sarasota, FL 34233

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Witness Date

PATIENT LABEL

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EMERGENCY CONTACT INFORMATION

Relationship: _____ Phone: _____

Name: _____

CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Suncoast Endoscopy of Sarasota.

Do we have your permission to:

Call you at home? ☐ Yes ☐ No

If yes, may we leave the following information on your home answering machine or voicemail:

Appointment Information ☐ Yes ☐ No
Billing Information ☐ Yes ☐ No
Medical Information ☐ Yes ☐ No

May we call you at work? ☐ Yes ☐ No

If yes, may we leave the following information at your work answering machine or voicemail:

Appointment Information ☐ Yes ☐ No
Billing Information ☐ Yes ☐ No
Medical Information ☐ Yes ☐ No

PHONE NUMBER YOU CAN BEST BE REACHED _____

I give my permission to share the following information with the person(s) named below:

Name: _____ Relationship _____
Appointment ☐ Yes ☐ No Billing ☐ Yes ☐ No

Name: _____ Relationship _____
Appointment ☐ Yes ☐ No Billing ☐ Yes ☐ No

_____ _____
Patient Signature Date

_____ _____
Witness Date

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CONSENT TO MEDICAL SERVICES INCLUDING TRANSFUSION(S)

Please INITIAL EACH Line (1 thru 11)

_____ 1. I **DO / DO NOT** ← ***(circle one – applies to #1 only)***
authorize the administration of transfusions of whole blood or blood products to me as may be deemed advisable by the attending physician. I understand that despite the exercise of due care the transfusion or blood or blood products is always attended with the possibility of some ill effects such as the transmission of hepatitis, HIV or certain other diseases, accidental immunization, or allergic reaction. I understand that in an emergency it may be necessary for the patient's well being to use existing stocks of blood which may not include the most compatible blood types.

_____ 2. In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor or employee of the facility, I consent to testing for HIV or hepatitis.

_____ 3. I hereby consent to the presence of other person(s) for the sole purpose of observation and/or education. I understand that this individual(s) will not participate in the actual procedure.

_____ 4. I understand that if I am pregnant or if there is any possibility I may be pregnant, I must inform the facility immediately since the scheduled procedure could cause harm to my child or to myself.

_____ 5. I understand that in the rare event hospitalization is required during or immediately after procedure, my physician will arrange for my transfer to a local hospital.

_____ 6. I verify I have not eaten or taken fluids, not even water, since midnight, unless otherwise instructed by my physician.

_____ 7. Suncoast Endoscopy of Sarasota has provided me with information regarding the Patient's Bill of Rights & the Privacy Act (HIPAA) so I may be fully informed prior to treatment. (Privacy & Rights posters are posted in lobby)

_____ 8. Suncoast Endoscopy of Sarasota has informed me that they do not honor advanced directives (living wills) at the facility.

_____ 9. I release the facility from any responsibility for loss and/or damage to money, jewelry or other valuables I brought into the facility.

_____ 10. **I understand that it is my responsibility and I have arranged for a responsible adult to drive me home from Suncoast Endoscopy and remain with me following my procedure. I acknowledge that I have been advised by facility personnel not to drive until the effects of any medications have worn off. I understand this to mean that I should not drive until the day after my procedure or as directed by my physician.**

_____ 11. **I understand it is my responsibility to fully disclose all my medical history.**

_____ 12. **I have received a copy of the nondiscrimination notice and language assistance tag lines (posted in lobby).**

Date_____**Time**_____**Patient's Signature**_____

Date_____**Time**_____**Witness to Signature**_____

If patient is unable to sign complete the following:

Date_____**Time**_____**Signature**_____

Relationship_____**Witness to Signature**_____

PATIENT LABEL

IPS

SunCoast Anesthesia Partners, LLC
PO BOX 919368
Orlando, FL 32891
1- 888-337-3509 or 941-209-5410

Dear Patient:
The surgery or procedure you have had or are about to receive has at least three (4) separately billable components which consist of:

- The professional services of the surgeon
- The professional services of the anesthesia provider (CRNA and/or physician)
- The facility fee (for use of the surgical or procedural site)
- Pathology services

SunCoast Anesthesia Partners, LLC (SAP) provides the professional anesthesia services and Innovative Practice Strategies (IPS) is the billing agent for SAP.

Anesthesia is commonly a covered component of your surgery or procedure. As a courtesy to you, the bill/claim for your anesthesia services, as well as any subsequent appeals, will be filed on your behalf directly with your primary insurance carrier. We, SAP and IPS, accept assignment of benefits and your insurance carrier should send the payment directly to the remittance address above. If we have secondary insurance information about you, we will file a claim on your behalf with that insurer for the amount not paid by your primary insurance. If no secondary insurance information is provided at the time of service, we will send you a statement for the co-insurance amount due according to your primary insurance carrier. You will be responsible for the deductible and/or co-pay amounts determined by your policy/plan.

In the event that SAP is not a participating provider with your insurance plan, IPS will work with your insurance carrier through various appeal efforts in order to minimize any penalties or costs that your insurance says that you owe. We are often able to negotiate with your insurer to reduce your out-of-pocket expenses due to SAP out-of-network status, but we cannot guarantee a result. You will also be required to pay the deductible and/or co-pay amounts determined by your policy/plan.

In order for us to communicate and correspond with your insurer about your surgery or procedure, we need you to give us permission to do so. Please read and sign the authorizations below which allow us to use and/or disclose your personal health information to your insurer and to take action on your behalf, as your representative, for the purposes of obtaining reimbursement and to prepare and manage appeals of coverage determination. These steps allow us to reduce your out-of-pocket expense as much as possible.

By signing this authorization, I authorize Innovative Practice Strategies, LLC ("IPS") and/or SAP to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below. This authorization permits IPS and/or SAP to use or disclose to my insurance company: _____ any individually identifiable health information related to my surgery or procedure that took place on _____ at Suncoast Endoscopy Center. I retain the right to revoke this authorization at any time; however, such revocation shall not affect actions that IPS has already undertaken prior to my revocation in order to process my claim.
By signing this authorization, I hereby appoint IPS and/or SAP to act on my behalf as my authorized representative for all claims, services, and appeals related to my surgery or procedure that took place on _____ at Suncoast Endoscopy Center.

By signing this authorization, I request that payment of authorized benefits be made on my behalf to IPS and/or SAP for any services or goods provided by SAP. I authorize the release of any and all medical information that is necessary to process claims arising from the services herein referenced. I understand that some, and perhaps all, of the services may be determined by my insurance carrier, which cannot practice medicine, to be non-covered services and that such services may not be considered medically necessary under my insurance contract, regardless of how appropriate or medically necessary they may be. I understand that I am responsible for payment of any charges in full including non-covered services and deductible and/or co-payment amounts determined by my insurance to be due from me. IPS and/or SAP will not request a pre-authorization from your insurance company for procedures provided by IPS and/or SAP. I understand that it is my responsibility to insure that prior authorization for anesthesia services, if required, is on file with IPS and/or SAP prior to my receiving anesthesia services from SAP. I understand that I am responsible for payment in full of all charges submitted by IPS to my insurance company if prior authorization for anesthesia services was required and not obtained.

I acknowledge that I am voluntarily completing this authorization and affirm that no undue forces were utilized to obtain my cooperation.

Signature: _____ **Print Name:** _____ **Date:** _____

Witness: _____ **Signature:** _____ **Date:** _____

PLACE PATIENT STICKER HERE

WHO IS DRIVING YOU HOME TODAY?

DRIVER'S NAME:_____

RELATIONSHIP TO YOU:_____

DRIVER'S PHONE NUMBER:_____
PLEASE INDICATE RESPONSE:
DRIVER WILL WAIT IN LOBBY: _____YES _____NO
DRIVER WILL NEED TO BE CALLED: _____YES _____NO
CAN DRIVER BE AT BEDSIDE IN RECOVERY ROOM:_____YES _____NO

Suncoast Endoscopy of Sarasota is committed to providing the highest level of patient care. To achieve this objective we ask our patients or their caretaker to complete a brief patient satisfaction survey after their visit.

To better serve you we have automated this process. Within 48 hours, you will receive an email providing you with a link to complete our survey. The survey is performed online via a secure internet connection to the independent company we have hired to gather survey results. Simply follow the instructions and give us your feedback. Patients who complete the survey online will be entered into a monthly drawing for a $100 gift certificate to Amazon.com

Please write legibly and provide the email address to forward the survey to in the boxes below:

Privacy Statement: We are committed to protecting the confidentiality of our patient's information and identities and under no circumstances will your information be disclosed or used for marketing purposes.

PATIENT LABEL

Suncoast Anesthesia Partners Pre-Anesthesia Evaluation

Patient to fill out sections 1 and 2 — **Section 1**

Date of Procedure: _____

Proposed Procedure: _____

Previous Anesthesia & Complications:

□ **None** □ Malignant Hyperthermia: (+) (-) _____

□ Family History: (+) (-) _____

□ Nausea and Vomiting: (+) (-) _____

□ Other:

Allergies:

□ **NKDA** □ **EGGS** □ **NUTS** □ **SOY**

_____

_____

_____

Section 2

•Respiratory: (No Problems □)

□ COPD
□ TB
□ Infection
□ Bronchitis
□ Smoker
If yes, ____packs/day for____ years
□ Pneumonia
□ Abnormal X-Ray
□ Sleep Apnea
□ Asthma
□ Pulmonary Embolus

Cardiovascular: (No Problems □)

□ Angina/Chest Pain
□ Heart Failure
□ Coronary Artery Disease
□ Heart Attack
□ Hypertension
□ Surgery or Angioplasty when: _____
□ Valvular disease
□ Vascular Disease
□ Blood Clots
□ Arrhythmias
□ Murmurs
□ Pacemaker

• Gastrointestinal (No Problems □)

□ Reflux
□ Hiatal Hernia
□ Hepatitis
□ Jaundice
□ Liver disease
□ GI Bleeding
□ UlcersPUD
□ Cirrhosis
□ Crohn's
□ Ulcerative Colitis
□ Alcohol Consumption
Amount per week: _____
□ Polyps
□ Diverticulosis

Renal and Endocrine: (No Problems □)

□ Diabetes (Normal Blood Sugar:___)
□ Thyroid disease
□ Kidney disease
□ Dialysis: When: _____

Other: (WNL □)

□ Anemia
□ Sickle Cell trait
□ Coagulation or bleeding disorders
□ Cancer
□ Chemo/radiation:
When:
□ Hypercholesterolemia
□ Leukemia
□ Obesity
□ Easy Bruising
□ Hemophilia
□ Blood Transfusion
□ HIV

• Neuro/Musculoskeletal: (WNL □)

□ Stroke
□ Mini-Stroke
□ Dizziness
□ Seizures
□ Migraines
□ Arthritis
□ Muscle weakness disease/paralysis
□ Alzheimer's
□ Anxiety
□ Depression
□ Spinal Cord injury

• Anything Else?: _____

• All current medications: _____

Section 3

Center Medical Staff only below this line

• Pregnancy test: (+) (-) **• Signed Waiver ( )** **N/A ( )** **• Post Hysterectomy ( )** **• Post Menopausal ( )**

• PE (Day of Surgery): **VS: BP**_____ **P**_____ **R**_____ **O2Sat**_____ **Temp:**_____

• □ **Male /** □ **Female** **• Age:** _____ **• Height:**_____ **• Weight:**_____

Gen/psycho-social: _____ **Airway:** _____

CV:_____ **Lungs:** _____

• Plan: □ Deep Sedation/General □ Other: _____

Patient acceptable for anesthesia: □ **Yes** □ **No**

(If no, see Progress Notes for Explanation)

ASA PS: I II III IV

Consent: Discussed with patient/responsible adult who agrees and understands: □ Yes □ No

• Planning Anesthesia;/ Special Monitors: _____ Pre-anesthesia meds ordered:_____

Date: _____ Time: _____ Evaluator Signature (Anesthesiologist(CRNA)_____

Date of Re-Evaluation: _____ Time: _____ am/pm **Last PO intake:** _____

Anesthesiologist/CRNA: _____

Name Plate

Last: _____

First: _____

Medical record # _____

Progress Note:

SUNCOAST ENDOSCOPY OF SARASOTA

Patient Acknowledgement
Receipt of Privacy Notice

I, _____ hereby affirm that I have received a copy of the *Notice of Privacy Practices* from Suncoast Endoscopy of Sarasota. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority (if applicable)

▼▼▼ FOR OFFICE USE ONLY ▼▼▼

Received by:	
Date Received:	Time Received:
Patient Declined ☐	
Staff Signature:	

SUNCOAST ENDOSCOPY MEDICATION RECONCILIATION FORM

[ ] NO KNOWN ALLERIES

ALLERGIES	REACTION

[ ] NO MEDICATIONS *[ ]SEE DISCHARGE INSTRUCTIONS*

MEDICATION

******List all medications, including over the counter and herbal meds, and all vitamins, minerals, and supplements. Please include any medications stopped for this procedure.******

MEDICATION	DOSE	HOW OFTEN	LAST DOSE	FOR DOCTOR'S INSTRUCTIONS ONLY: CONTINUE	FOR DOCTOR'S INSTRUCTIONS ONLY: STOP TAKING	COMMENTS

New Medication to Take Following Today's Visit:

1.
2.

Discharge Order: MD evaluated and cleared patient for discharge to Home / Hospital.
MD Time:_____ **PACU RN Time:**_____

FOR STAFF USE ONLY	
Preop:	**PATIENT LABEL**
Anesthesia:	
Circulator:	
PACU:	
Physician:	

I acknowledge that I have received a copy of this form:_____

Patient Signature