# Center for Special Surgery

4650 4th Street North o St. Petersburg, Florida 33703

Dear Patient,

The enclosed information is being supplied to every patient who accesses our Surgery Center. We are required to provide you with the attached information both written and verbally.

**We "*MUST*" speak to you "*PRIOR*" to the day of your procedure so that we do not have to cancel and reschedule when you come in.**

We attempt to call all patients prior to the day of your procedure. If we do not contact you it is important that you call us at (727) 527-1919 to ensure that we discuss your patient rights and financial information prior to the day of your procedure.

We want to make your visit with us as comfortable and efficient as possible. If at any time during your visit with us we can do anything to assist you, please let us know or call us at (727) 527-1919.

**Thank you in advance for making us your provider of choice.**

**Surgery Center Rules**

In 1990, Congress passed a federal law called the "Patient Self-Determination Act", which requires all adult patients to be informed about their right to refuse or accept medical or surgical treatment and their right to execute an Advance Directive. The term advance directive stands for a document that communicates the person's wishes as to what medical or surgical care that patient wants to receive if he/she is unable to convey those directions. These documents are known by different names in various states and may be presented to you as a "Living Will, "Healthcare Durable Power of Attorney", or an "Advance Healthcare Directive."

In surgery centers where patients are admitted and expected to go home after surgery there is an expectation that in the event of an emergency, all treatment available to resuscitate a person will be rendered regardless of any pre-written document with contrary instruction. Since the person has the right to these documents, we do not ask them to waive their rights or even suspend them; we only ask for the right to resuscitation while being in our facility.
That is the purpose of the documents enclosed.

The purpose of requesting's Advance Directive is to know his/her wishes and have them documented in the event of an occurrence where he/she may have continuation of care at another facility. In the rare event of refusing to consent to resuscitative measures, the center would follow their written policy to refuse surgery and assist the patient in scheduling their surgery elsewhere.

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**Advance Directives Policy**

**Standard** An Ambulatory Surgery Center, by its nature, performs predominantly elective procedures. The Surgery Center does not provide continuing care, and the need for Advance Directives has not been established for same day elective surgery patients.

**Policy** The Surgery Center will not honor any patient or family request for a "No Code" or "DNR" for any procedure scheduled at the Center. If the patient should present with an Advance Directive (i.e., Living Will) that is to be followed in the event he/she could not make his/her wishes known concerning emergency life prolonging procedures, the following procedure will be followed.

**Procedure** The patient and physician will be notified that the procedure will have to be cancelled if they are insistent on a "DNR" status.

In the event of a transfer of the patient to another medical facility, the receiving facility will be notified in advance of the transfer that the patient has Advance Directives.

If the patient does not have an Advanced Directive, an informational brochure will be provided.

# PATIENT CONSENT TO RESUSCITATIVE MEASURES

## *NOT A REVOCATION OF ADVANCE DIRECTIVES OR MEDICAL POWERS OF ATTORNEY*

ALL PATIENTS HAVE THE RIGHT TO PARTICIPATE IN THEIR OWN HEALTH CARE DECISIONS AND TO MAKE ADVANCE DIRECTIVES OR TO EXECUTE POWERS OF ATTORNEY THAT AUTHORIZE OTHERS TO MAKE DECISIONS ON THEIR BEHALF BASED ON THE PATIENT'S EXPRESSED WISHES WHEN THE PATIENT IS UNABLE TO MAKE DECISIONS OR UNABLE TO COMMUNICATE DECISIONS. THIS SURGERY CENTER RESPECTS AND UPHOLDS THOSE RIGHTS.

HOWEVER, UNLIKE IN AN ACUTE CARE HOSPITAL SETTING, THE SURGERY CENTER DOES NOT ROUTINELY PERFORM "HIGH RISK" PROCEDURES. MOST PROCEDURES PERFORMED IN THIS FACILITY ARE CONSIDERED TO BE OF MINIMAL RISK. OF COURSE, NO SURGERY IS WITHOUT RISK. YOU WILL DISCUSS THE SPECIFICS OF YOUR PROCEDURE WITH YOUR PHYSICIAN WHO CAN ANSWER YOUR QUESTIONS AS TO ITS RISKS, YOUR EXPECTED RECOVERY AND CARE AFTER YOUR SURGERY.

**THEREFORE, IT IS OUR POLICY, REGARDLESS OF THE CONTENTS OF ANY ADVANCE DIRECTIVE OR INSTRUCTIONS FROM A HEALTH CARE SURROGATE OR ATTORNEY-IN-FACT, THAT IF AN ADVERSE EVENT OCCURS DURING YOUR TREATMENT AT THIS FACILITY WE WILL INITIATE RESUSCITATIVE OR OTHER STABILIZING MEASURES AND TRANSFER YOU TO AN ACUTE CARE HOSPITAL FOR FURTHER EVALUATION. AT THE ACUTE CARE HOSPITAL FURTHER TREATMENT OR WITHDRAWAL OF TREATMENT MEASURES ALREADY BEGUN WILL BE ORDERED IN ACCORDANCE WITH YOUR WISHES, ADVANCE DIRECTIVE OR HEALTH CARE POWER OF ATTORNEY. YOUR AGREEMENT WITH THIS POLICY BY YOUR SIGNATURE BELOW DOES NOT REVOKE OR INVALIDATE ANY CURRENT HEALTH CARE DIRECTIVE OR HEALTH CARE POWER OF ATTORNEY.**

IF YOU DO NOT AGREE TO THIS POLICY, WE ARE PLEASED TO ASSIST YOU TO RESCHEDULE THE PROCEDURE. PLEASE CHECK THE APPROPRIATE BOX IN ANSWER TO THESE QUESTIONS. HAVE YOU EXECUTED AN ADVANCE HEALTH CARE DIRECTIVE, A LIVING WILL, OR A HEALTHCARE POWER OF ATTORNEY THAT AUTHORIZES SOMEONE TO MAKE HEALTH CARE DECISIONS FOR YOU?

- ☐ YES, I HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY.
- ☐ NO, I DO NOT HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY.
- ☐ I WOULD LIKE TO HAVE INFORMATION ON ADVANCE DIRECTIVES.

**IF YOU CHECKED THE FIRST BOX "YES" TO THE QUESTION ABOVE, PLEASE PROVIDE US A COPY OF THAT DOCUMENT SO THAT IT MAY BE MADE A PART OF YOUR MEDICAL RECORD.**

*BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED. IF I HAVE INDICATED I WOULD LIKE ADDITIONAL INFORMATION, I ACKNOWLEDGE RECEIPT OF THAT INFORMATION.*

*BY:* ________________________________________
(PATIENT'S SIGNATURE)

| Patient's **Last Name**: | Patient's **First Name**: | Date: |
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| | | |

**If consent to the procedure is provided by anyone other than the Patient, this form must be signed by the person providing the consent or authorization.**

***I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED.***

BY: ____________________________________ __________________________________________
(Signature) (Print Name)

Relationship to Patient

☐ COURT APPOINTED GUARDIAN ☐ ATTORNEY IN FACT
☐ HEALTH CARE SURROGATE ☐ OTHER ______________________________________________

**SUMMARY OF THE FLORIDA'S BILL OF RIGHTS AND RESPONSIBILITIES**

Florida law requires that your health care provider or health care facility recognize your rights when you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities are listed below.
The patient and /or patient's representative:

- Has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
- Has the right to a prompt and reasonable response to questions and requests.
- Has the right to know who is providing medical services and who is responsible for his or her care.
- Has the right to know what patient support services are available, including whether an interpreter is available or if he or she does not speak English.
- Has the right to know what rules and regulations apply to his or her conduct.
- Has the right to be given by his health care provider information concerning diagnosis, planned course of treatment, alternatives, risk and prognosis.
- Has the right to refuse treatment, except as otherwise provided by law.
- Has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- Who is eligible for Medicare has the right to know, up front and in advance of treatment, whether the health care provider or health facility accepts the Medicare assignment rate.
- Has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- Has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- Has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- Has the right to treatment for an emergency medical condition that will deteriorate from failure to provide treatment.
- Has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- Has the right to express grievances regarding his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- Has the right to exercise his or her rights without being subjected to discrimination or reprisal.
- Is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- Is responsible for reporting unexpected changes in his or her condition to the health care provider.
- Is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her
- Is responsible for following the treatment plan recommended by the health care provider.
- Is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility
- Is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- Is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- Is responsible for following health care and facility rules and regulations affecting patient care and conduct.
- This is to inform you that certain physicians that perform procedures at Center for Special Surgery have a partnership interest/ownership in the facility. If you have any questions regarding your physician, please do not hesitate to ask.
- Your physician may not carry malpractice coverage. If you have questions about malpractice coverage, please discuss those with your physician.
- Anesthesia services are provided by independent Anesthesia Providers.
- Is responsible for providing the Center with an accurate and complete list of all medications including over the counter and herbal supplements.

If you have a complaint against this facility you can contact the Administrator at 727-527-1919 or write to Center for Special Surgery, 4650 4th Street North, St. Petersburg, FL 33703

**FILING COMPLAINTS**

If you have a complaint against a hospital or ambulatory surgical center, call the Consumer Assistance Unit at 1-888-419-3456 or write to the address listed below.

AGENCY FOR HEALTH CARE ADMINISTRATION
CONSUMER ASSISTANCE UNIT
2727 MAHAN DRIVE / BLD. 1
P.O. BOX 14000
TALLAHASSEE, FL 32308
Website for Medicare beneficiary Ombudsman www.cms.hhs.gov/center/ombudsman.asp