Eye Surgery Center of North Florida

7205 Bonneval Road, Jacksonville, Fl 32256

Medication List

Patient Name: ____

Are you currently taking any medications? If so, please list them below.

Medication	Dosage	How Often
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________

Were you instructed to STOP taking any medications? If so, please list them below.

Medication	Dosage	How Often
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________

Were you instructed by the doctor to TAKE any medications? If so, please list them below.

Medication	Dosage	How Often
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________
____________________________	____________________	____________________

Reviewed by ESCNF Nurse: _________________________ Date:____________

Eye Surgery Center of North Florida

7205 Bonneval Road • Suite 2 • Jacksonville, FL 32256

Please Fax this Form to:
(904) 861-3599

Pre-Operative History and Physical

_______________________________________ is scheduled for eye surgery on ____________________________ under local/IV section anesthesia. In order to do so, I am in need of your evaluation of his/her general physical condition, with special emphasis on heart and lungs. If you feel that a preoperative EKG or any laboratory tests are indicated for this patient prior to local/IV sedation anesthesia, please provide us with those results.

Much appreciation,

□ Frank W. Bowden, III, M.D., FACS □ Stephen Ume, M.D., M.S. □ Kristina Price, M.D.

Allergies:

Medications:

Pertinent medical or surgical history:

PHYSICAL EXAMINATION:
Vital Signs: BP- P- R- Temp-
HEENT:
Lungs:
Heart:
Abdomen:
Extremities:
Neurologic:
LAB (if appropriate):
Height:__________ Weight:__________ BMI:_______

IMPRESSION:

RECOMMENDATIONS:

☐ **Cleared for surgery**

☐ **NOT cleared for surgery.**

Must be signed by a M.D.

____
Doctor's Signature

_____________________ ____________________________ __________________
Date Doctor's Name (Please Print) Office Phone #

Please fax this form to (904) 861-3599

Eye Surgery Center of North Florida

Authorization for Release of Medical Information

I, the undersigned, hereby authorize the release of medical, psychiatric, alcohol, and/or drug abuse, HIV testing, and/or AIDS information as described below:

PATIENT LABEL

From the Eye Surgery Center of North Florida, 7205 Bonneval Road, Jacksonville, FL 32256.

I understand that this authorization will remain in effect for on year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any information already released. I understand that I am not obligated to sign this authorization, and that my ability to obtain treatment from Eye Surgery Center of North Florida will not depend in any way on whether I sign this Authorization. I understand I have the right to receive a copy of this authorization.

I understand that State and federal law may prohibit the recipient from re-disclosing information provided pursuant to this authorization, but that neither Eye Surgery Center of North Florida nor Bowden Eye Associates has any control over the recipient and cannot guarantee that the recipient will not re-disclose such information.
I understand that I may be charged a cost-based fee for such records of up to $1.00 per page for paper records (up to $2.00 per page on non-paper records) and an administrative fee of $1.00 for each year of records requested. Fee will be waived for copies provided to another healthcare provider for continuing care.

I understand that I must submit a Request form in person for the personal release or request of medical records.

By signing below, I authorize Eye Surgery Center of North Florida to release medical information about me as described above.

___________________________________ ___________________

Patient/Guardian Signature Date

___________________________________ ___________________

Witness Signature Date

Eye Surgery Center of North Florida
7205 Bonneval Road, Suite 2, Jacksonville, FL 32256

Written Disclosure Form

Florida Law requires that we disclose to you our investment interest in the entity to which you are being referred for medical treatment. Frank W. Bowden, III, M.D., FACS has an investment interest in Eye Surgery Center of North Florida, LLC, a Florida limited liability company (the "Company"), with its principal place of business located at 7205 Bonneval Road, Jacksonville, FL 32256. The Company wholly owns the Eye Surgery Center of North Florida, LLC.

You have the right to obtain the items or services for which you have been referred from the Surgery Center or from the provider or supplier of your choice.

We have provided for you below the names of two alternative sources of health care items or services available to you.

Orange Park Surgery Center
Jacksonville Surgery Center

To acknowledge your receipt of this written disclosure form, we request that you please sign this letter on the space provided below so that we may have accurate record that you have been informed pursuant to Florida law of our investment interest in the Surgery Center to which you are being referred.

____
Patient's Signature

NOTICE OF PRIVACY PRACTICES

EYE SURGERY CENTER OF NORTH FLORIDA

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose health information for payment purposes. For Example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following reasons:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in out policies, we will change our Notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

Effective Date: November 1, 2007

I,

Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

____
Signature

____
Date

If not signed, reason why acknowledgement was not obtained:
____
____

Staff Witness seeking acknowledgement

____
Signature

____
Date

Eye Surgery Center of North Florida

7205 Bonneval Road, Ste. 2, Jacksonville, FL 32256

Patient Name:

As a patient of the Eye Surgery Center of North Florida, I understand that all valuables should remain with my family member or person of transportation. Employees of the Eye Surgery Center of North Florida will not be responsible for valuables nor will they accept any valuables to store.

____ ________________

Patient Signature Date

____ ________________

Signature of Family/ Transportation* Date

*Signature of Family/Transportation states that member has received all valuables.

____

ESCNF Employee Witness

DISCHARGE AND WAIVER OF
EYE SURGERY CENTER OF NORTH FLORIDA

I, [ ] hereby agree and acknowledge as follows:

Witness: __________

I have chosen Eye Surgery Center of North Florida to perform my surgery. As indicated below, I understand that the Eye Surgery Center of North Florida has contracted with entities/physicians and their staff and employees to provide certain services to me. I further understand that the entity's/physician's staff or employees may include, but are not limited to, physicians, physician's assistants (P.A.), advanced registered nurse practitioners (ARNP), certified registered nurse anesthetists (CRNA), student registered nurse anesthetists (SRNA), anesthesia assistants, registered nurses (RN), licensed practical nurses (LPN), medical students, nursing students, or laboratory technicians.

Anesthesia Services:
Eye Surgery Center of North Florida has contracted with North Florida Anesthesia Consultants to provide anesthesia services to you. North Florida Anesthesia Consultants is an independent contractor of Eye Surgery Center of North Florida and Eye Surgery Center of North Florida does not have any control over the work performed by North Florida Anesthesia Consultants or its staff.

Laboratory Services:
Eye Surgery Center of North Florida has contracted with Ameripath to provide laboratory services. Ameripath is an independent contractor of Eye Surgery Center of North Florida and Eye surgery Center of North Florida does not have any control over Ameripath or the Laboratory's staff.

Your physician, Dr. ______________________, is not an employee of Eye Surgery Center of North Florida; therefore, the services provided by Eye Surgery Center of North Florida do not include the services provided by Dr. ________________________ or his/her staff.

Eye Surgery Center of North Florida does not employee any physicians, osteopathic physicians, doctors of podiatric medicine, doctors of chiropractic, physician's assistant (P.A.), advanced registered nurse practitioners (ARNP), certified registered nurse anesthetists (CRNA), student registered nurse anesthetists (SRNA), anesthesia assistant, medical students, or nursing students. If any such persons or entities provide care to me as a result of my treatment at Eye Surgery Center of North Florida, including but not limited to Dr. ____________________, I understand that the person or entity is an independent contractor, and not an employee, of Eye Surgery Center of North Florida.

To the extent that Eye Surgery Center of North Florida is obligated by contract, statue regulation or common law to provide any services other than that of nursing services, Eye Surgery Center of North Florida has delegated those services to independent contractors.

I discharged Eye Surgery Center of North Florida of any and all contractual, statutory, regulatory, or common law duties, regardless of whether said duties are delegable or non-delegable, to provide any services to me other than nursing services.

Acknowledgement: I acknowledge that I have read this Discharge and Waiver in its entirety and understand all its provisions. To the extent that I did not understand any provisions, I acknowledge that the Eye Surgery Center of North Florida provided me with the opportunity to ask questions and that the Eye Surgery Center of North Florida answered my questions to my satisfaction.

By:____ DATE: _______________________
Patient/Patient Representative's Signature