David G. Berry, MD, FACS
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Mark Zuzga, DO, FACOS, RVT

Surgical Associates of West Florida

Dear Patient:

Thank you for choosing Surgical Associates of West Florida to provide your surgical care. In order to make your visit more efficient and pleasant, please take time to read the following information.

- Please complete the attached paperwork prior to arriving for your appointment. If you do not complete your paperwork prior to your appointment, please arrive 30 minutes early to your appointment.
- Please bring your insurance card and picture ID.
- Copays will be collected at time of service.
- As a courtesy to others, please refrain from wearing strong perfume / cologne to your appointment.
- If you must take a call on your cell phone, we ask that you step out of the office into the hallway.

If you have any questions, please feel free to contact us at #727-712-3233.

Thank you.

Visit Our Web Site at **www.WestFloridaSurgery.com**

Countryside Location
1840 Mease Drive, Ste 301
Safety Harbor, Florida 34695
(727) 712-3233, Phone
(727) 712-1853, Fax

Dunedin Location
646 Virginia Street, Suite 201
Dunedin, Florida 34698
(727) 712-3233, Phone
(727) 712-1853, Fax

Trinity Location
2102 Trinity Oaks Blvd, Suite 204
New Port Richey, Florida 34655
(727) 712-3233, Phone
(727) 712-1853, Fax

Clearwater Location
430 Morton Plant St, Suite 301
Clearwater, Florida 33756
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PATIENT INFORMATION FORM

** All information is kept confidential. Please answer honestly to assure the best possible treatment for you. Please complete all pages. **

(Please Print) Today's Date: _____

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____ Age: _____

Street Address: _____ E-Mail Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Height: _____ Weight: _____

Social Security Number: _____ Sex: ○ Male ○ Female

Driver License Number: _____

Marital Status ◉ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Employer: _____ Occupation: _____

PRIMARY AND REFERRING PHYSICIAN INFORMATION:

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

SPOUSE/GUARDIAN INFORMATION:

Spouse's Name or Guardian's Name: _____

Spouse's Employer: _____ Spouse's Occupation: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Phone Number: _____

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Countryside Location	**Dunedin Location**	**Trinity Location**	**Clearwater Location**
1840 Mease Drive, Ste 301	646 Virginia Street, Suite 201	2102 Trinity Oaks Blvd, Suite 204	430 Morton Plant St, Suite 301
Safety Harbor, Florida 34695	Dunedin, Florida 34698	New Port Richey, Florida 34655	Clearwater, Florida 33756
(727) 712-3233, Phone	(727) 712-3233, Phone	(727) 712-3233, Phone	(727)712-3233, Phone
(727) 712-1853, Fax	(727) 712-1853, Fax	(727) 712-1853, Fax	(727)712-1853, Fax

Physician's Initials _____

David G. Berry, MD, FACS
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Surgical Associates of West Florida

CLINICAL HISTORY FORM

PATIENT NAME: _____ **SSN #:** _____ **TODAY'S DATE** _____

REASON FOR YOUR VISIT

What is the reason for this visit? _____

_____

_____

How long have you had the problem? _____

_____

_____

CURRENT MEDICATIONS *(List all medications / herbal / dietary supplements / alternative medications and treatments you are currently taking)*

Medication	*Dosage*	*# Per Day / Frequency*	*Reason for Taking*

****** Please list any other current medications on the other side of this sheet. *******

MEDICATION ALLERGIES *(Are you allergic to any medications?)*

Medication	*Reaction*

Do you have any problems with anesthesia? ○ Yes ◉ No

Have you had an allergic reaction to tape? ○ Yes ◉ No

Do you have an allergy to any latex products? ○ Yes ◉ No

PAST SURGICAL HISTORY

Check all that apply	*Year*		*Year*		*Year*
☐Appendectomy	_____	☐Hernia, Inguinal	_____	☐Other _____	_____
☐Breast Biopsy	_____	☐Hernia, Ventral	_____	☐Other _____	_____
☐Chest Surgery	_____	☐Mastectomy	_____	☐Other _____	_____
☐Coronary Artery Bypass	_____	☐Prostate	_____	☐Other _____	_____
☐Gall Bladder	_____	☐Tonsillectomy	_____	☐Other _____	_____
☐Hysterectomy, Abdominal	_____	☐Vascular Surgery	_____	☐Other _____	_____
☐Hysterectomy, Vaginal	_____	☐Tubal Ligation	_____	☐Other _____	_____

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CLINICAL HISTORY FORM (Continued)

PATIENT NAME: _____ **SSN #:** _____ **TODAY'S DATE** _____

PAST MEDICAL HISTORY (Please list all major medical problems)

☐ Stroke	☐ High Blood Pressure	☐ Kidney Stones / Disease
☐ Seizures	☐ Diabetes	☐ Anemia
☐ Glaucoma	☐ Juvenile Onset Diabetes	☐ Cancer
☐ Emphysema	☐ Thyroid	☐ Bleeding Disorder
☐ Asthma	☐ Hepatitis	☐ Diverticulosis
☐ Heart Attack / Disease	☐ Elevated Cholesterol/Triglycerides	☐ Angina
☐ Gallstones	☐ Arthritis	☐ Lung Disorders
☐ Vein Trouble	☐ Other _____	☐ Other _____
☐ Other _____	☐ Other _____	☐ Other _____

FAMILY HISTORY

Family Member	*Alive/Deceased*	*Age*	*Health Problems (i.e. cancer, heart disease, etc)*
Father	_____	_____	_____
Mother	_____	_____	_____
Brother / Sister	_____	_____	_____
Brother / Sister	_____	_____	_____
Brother / Sister	_____	_____	_____
Children	_____	_____	_____

SOCIAL HISTORY

Tobacco ○ None ○ Currently smoke ___ packs/day and have done so for _____ years
○ Previously smoked _____ packs/day for _____ years. Stopped in _____
○ Smokeless Tobacco

Alcohol ○ None ○ Minimal ○ Moderate ○ Heavy ○ Previously Heavy

Caffeine ○ None ○ 1-3 Servings Daily ○ 3-4 Servings Daily ○ More than 6 servings Daily

Drug Use ☐ _____ ☐ _____

PERSONAL HISTORY OF CANCER

Type of cancer ⊙ _____ ○ Not applicable

When was your cancer treated? _____

What type of cancer treatment did you receive? ○ Chemo Therapy ○ Radiation Therapy ⊙ Surgery

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CLINICAL HISTORY FORM (Continued)

PATIENT NAME: _____ **SSN #:** _____ **TODAY'S DATE** _____

SYSTEMS REVIEW *(Please place a check next to yes if the item applies to you)*

	Yes
GENERAL	
Weight Loss	☐
Weight Gain	☐
Insomnia	☐
Fever	☐
Night Sweats	☐
Chills	☐
Fatigue	☐
EYES	
Blurred Vision	☐
Double Vision	☐
Episodic Blindness	☐
Cataract (s)	☐
Glaucoma	☐
EARS	
Earache	☐
Ringing	☐
Infection	☐
Drainage	☐
Pain	☐
Mild Hearing Loss	☐
Hearing Impaired	☐
NOSE/THROAT	
Frequent Nosebleeds	☐
Hoarseness	☐
Sinus	☐
Difficulty Swallowing	☐
Bleeding Gums	☐
Sores in Mouth of Lips	☐
Chronic Sinus Congestion	☐
Allergies	☐
Hay Fever	☐
RESPIRATORY / LUNGS	
Wheezing	☐
Chronic Cough	☐
Emphysema or COPD	☐
Coughing up Blood	☐
TB or positive skin test	☐
Sleep apnea	☐
Pulmonary Embolus	☐
Asthma	☐
INFECTIONS	
HIV Positive	☐
History of Hepatitis	☐
Staph Infections	☐

	Yes
CARDIO / HEART	
Chest Pain or Angina	☐
Heart Skips	☐
Rapid Heart Rate	☐
Poor Circulation	☐
Murmur	☐
Heart Attack	☐
Shortness of Breath	☐
Cardiac Testing within the last year (i.e. EKG)	☐
Hypertension	☐
Pacemaker	☐
GI / DIGESTIVE	
Poor Appetite	☐
Abdominal Pain	☐
Nausea	☐
Vomiting	☐
Bloating	☐
Heartburn or GERD	☐
Diarrhea	☐
Constipation	☐
Blood in Stool	☐
Hemorrhoids	☐
Crohn's Disease	☐
Irritable Bowel Disease	☐
Ulcerative Colitis	☐
Gallstones	☐
GENITO-URINARY	
Difficulty Urinating	☐
Difficulty Holding Urine	☐
Frequent Urination at Night	☐
Blood in Urine	☐
Kideny Stones	☐
Herpes	☐
Men: Prostate Cancer	☐
Men: Discharge from Penis	☐
Women: Menopause	☐
Women: Hysterectomy	☐
MUSCULOSKELETAL	
Pain in Joints	☐
Pain in Muscles	☐
Muscle Weakness	☐
Chronic Back Problems	☐
Swollen Ankles	☐
Varicose Veins	☐

	Yes
SKIN	
Easy Bruising	☐
Ulcerations	☐
Rash	☐
Itching	☐
Psoriasis	☐
Non Healing Lesions	☐
History of Skin Cancer	☐
NEUROLOGICAL	
Dizziness	☐
Loss of Consciousness	☐
Transient Loss of Function	☐
Stroke	☐
Seizures	☐
EMOTIONAL	
Anxiety	☐
Depression	☐
Psychiatric Therapy	☐
ENDOCRINE	
Thyroid Disorder	☐
Masses	☐
Heat or Cold Intolerance	☐
Diabetes Under Treatment	☐
Excessive Thirst	☐
Excessive Hunger	☐
HEMATOLOGIC	
Anemia	☐
Bruise Easily	☐
Exessive Bleeding	☐
Swollen Glands	☐
Leukemia	☐
Lymphoma	☐
Transfussions	☐
Blood Clots	☐
Phlebitis	☐
Deep Venous Thrombosis	☐
Sickle Cell	☐
BREAST	
Lumps	☐
Cysts	☐
Cancer	☐
Breast Pain	☐
Family History	☐

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CLINICAL HISTORY FORM (Continued)

PATIENT NAME: _____ **SSN # :** _____ **TODAY'S DATE** _____

OTHER INFORMATION *(Please write below any other information not covered in this Clinical History Form that you feel the doctor or surgical staff should know about)*

_____
_____
_____
_____
_____

PATIENT'S SIGNATURE

I certify that, to the best of my knowledge, the above information is complete and accurate.

Patient's Signature: _____

Today's Date: _____

Thank you for choosing Surgical Associates of West Florida to provide your surgical care.

Surgical Associates of West Florida

Dedicated To Delivering Quality Surgical Care

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GENERAL PATIENT / PHYSICIAN AGREEMENT

Please read the following paragraphs, initial below each paragraph that you have read, understand, and agree to the same.

CONFIDENTIALITY:

In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method, and/or any physician that can assist with the care of the patient, as long as confidentiality is kept at the physician level. I have read, understand, and agree with the above.

Patient/Guardian Initials: _____ Date: _____

FAILURE TO FOLLOW PHYSICIAN ORDERS:

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility, thus releasing treating physician and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can included but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illness. I have read, understand, and agree with the above.

Patient/Guardian Initials: _____ Date: _____

FORM COMPLETION POLICY

The ever increasing time and cost burden required to complete the multitude of forms being requested by our patients requires **Surgical Associates of West Florida** to implement the following charge policy for all forms.

- **A fee of $25.00 for each request**

Forms that will be accessed a form completion fee include FMLA (Family & Medical Leave Act) forms, Disability forms, Back-To-Work forms, and miscellaneous forms. Fees DO NOT apply to Surgical Associates of West Florida's internal forms, such as the patient questionnaire.

When your forms are completed, Surgical Associates of West Florida will contact you to let you know that your forms are complete. Prior to the completed forms being distributed to patients, Surgical Associates of West Florida will collect the related fee via cash, money order, personal check, credit card, or debit card (MasterCard or Visa logo).

Patient/Guardian Initials: _____ Date: _____

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Surgical Associates of West Florida

ARBITRATION AGREEMENT BETWEEN DOCTOR AND PATIENT

Please read carefully.

This agreement is made between Surgical Associates of West Florida - SAWF and their physicians extenders, agents, employees, or any of the foregoing referred to hereinafter as "doctors" and_____ hereinafter referred to as "patient".

It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians**, or any other legal claimant.**

Disputes and Consideration: In the unfortunate event of any claim for medical malpractice or otherwise, and in consideration for this agreement, the parties would like to (a) keep things as simple as possible; (b) enhance early resolution of their differences;(c) avoid lengthy drawn out litigation through the courts; (d) avoid the stress associated with traditional litigation and jury trials; and (e) minimize all costs, expenses and attorney's fees. Therefore, the parties voluntarily agree to the following pursuant to their constitutional right to contract:

It is understood by the patient that he or she has voluntarily selected and he or she is neither required to use SAWF, nor any of the doctors involved in their treatment and that there are other competent physicians in Florida who may act as the patient's treating physician.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever related to personal injury, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statues.

I understand that by signing this agreement I am waving my right to a jury trial, and instead, have agreed to participate in arbitration.

This arbitration shall be binding and shall be in lieu of, and instead of, any trial by judge or jury. Each party shall choose one arbitrator and these two individual selected arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for under the Florida Rules of Civil Procedure and agree to be governed by the Florida Evidence Code and Chapters, 766 &768, Florida Statutes, in any matter subject to this arbitration agreement. The panel of three (3) arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction.

Prior to commencing any action under this Doctor-Patient Agreement, Patient must comply with the presuit notice and investigation requirements of Chapter 766, Florida Statutes.

Limitation of Damages: Patient agrees that in the event of any dispute with the Doctor, for any reason whatsoever, including any negligence claim relating to the diagnosis, treatment, or care of the Patient or any other personal injury claim, Patient's non-economic damages (including, but not limited to, damages for pain and suffering) shall be limited to a maximum of $250,000 per incident and shall be calculated on a percentage basis with respect to capacity to enjoy life, pursuant to the formula contained in Florida Statutes, Section 766.207. For example, if the Patient's injuries resulted in a 50% reduction in his or her capacity to enjoy life, this would warrant an award of not more than $125, 000 in non-economic damages. This limit applies regardless of the number of claimants or defendants in the arbitration proceeding. This limitation of damages provision does not limit or restrict in any way the Patient's right to seek all economic damages actually incurred by the Patient, including any medical expenses and lost wages.

Please read carefully.

Duty to Defend and Indemnify: For each individual or entity with a claim that is not bound by this agreement ("non-party"), it is the parties' intent that they shall adopt and comply with this agreement 100% so that the parties can avoid piecemeal litigation and ensure consistency, closure, and finality in one forum. For each non-party claim against the patient's physician brought outside this agreement, you shall (a) defend and (b) indemnify the patient's physician against said claim(s) up to the amount the chief arbitrator deems reasonable under the circumstances.

Severability Clause: If any provision of this Agreement shall be held invalid under any applicable laws, such invalidity shall not affect any other provision of this Agreement that can be given effect without the invalid provision. Further, all terms and conditions of this agreement shall be deemed enforceable to the fullest extent permissible under applicable law, and, when necessary, the court is requested to reform any and all terms or conditions to give them such effect.

By signing below, the patient confirms that:

- The Patient has had an opportunity to read this Doctor-Patient Agreement, or to have it read to him or her if necessary.
- The Patient indicates that they understand English or has had the Doctor-Patient Agreement translated for him or her by _____.
- The Patient has had an opportunity to ask questions about this Doctor-Patient Agreement.
- The Patient understands this Doctor-Patient Agreement and has no unanswered questions.
- The Patient has not been coerced or compelled to sign this Doctor-Patient Agreement, and does so if his or her own free will.
- The Patient is also aware that they may consult with an attorney before signing this Doctor-Patient Agreement.

This agreement shall remain in effect for all treatment and surgery provided to the patient, presently and at any future date.

BY SIGNING THIS DOCTOR-PATIENT AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Signature:_____ Date:_____

Parent, Guardian or Legal Representative Signature:_____

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Robert T. Roth, MD, FACS

Surgical Associates of West Florida

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NOTICE OF PRIVACY PRACTICES

** This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. **

At **Surgical Associates of West Florida**, we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Officer Manager: Pam Taylor at (727) 712-3233. This notice went into effect on April 14, 2003.

Acknowledgement: I have received a copy of **Surgical Associates of West Florida's** Notice of Privacy Practice.

_____	_____	_____
Patient / Guardian (Please Print Name)	Patient / Guardian (Signature)	Date

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Robert S. Davidson, MD, FACS
Robert T. Roth, MD, FACS

Surgical Associates of West Florida

Rick J. Schmidt, MD, FACS
Theodore R. Small, MD, FACS
Mark Zuzga, DO, FACOS, RVT

INSURANCE INFORMATION

PATIENT NAME: _____ **SSN # :** _____ **TODAY'S DATE** _____

**** Even though we will copy your insurance cards, please complete all of the information requested below. ****

PRIMARY INSURANCE:

Primary Insurance Carrier: _____ Phone #: _____
◉ PPO ○ POS ○ HMO ○ Other _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Subscriber's Social Security Number: _____ Subscriber's ID Number _____
Relationship to Subscriber: _____
Subscriber's Employer: _____ Work Phone: _____

SECONDARY INSURANCE:

Secondary Insurance Carrier: _____ Phone #: _____
○ PPO ○ POS ○ HMO ○ Other _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Subscriber's Social Security Number: _____ Subscriber's ID Number _____
Relationship to Subscriber: _____
Subscriber's Employer: _____ Work Phone: _____

WORKER'S COMPENSATION:

Is this a work related injury? ○ Yes ○ No (If yes, please provide the following information)
Claim Adjuster's Name: _____ Phone #: _____
Date of Injury: _____
Claim Number: _____
Contact at Employer: _____ Phone #: _____

FINANCIAL AGREEMENT:

I authorize Surgical Associates of West Florida to bill my insurance company for services rendered. I realize that I will be responsible for co-payments and deductibles at the time of services. Any portion not covered by insurance will be billed to me. If I am uninsured, payment is expected at the time of service. If it becomes necessary to collect any balance due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

I authorize Surgical Associates of West Florida to release medical information for insurance purposes. I authorize payment to be made directly to Surgical Associates of West Florida if an assignment is indicated by my insurance company. As a courtesy, Surgical Associates of West Florida will contact insurance companies for authorization for services required. Surgical Associates of West Florida is not responsible for lapses of insurance or for incorrect information.

I have read and understand the financial agreement above.

_____ _____ _____
Patient / Guardian (Please Print Name) Patient / Guardian (Signature) Date

Physician's Initials _____

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Robert T. Roth, MD, FACS

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Rick J. Schmidt, MD, FACS
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name**:** _____

Address:_____

City:_____State:_____Zip:_____

I hereby consent to the release and disclosure of my personal health information to:

Name (Individual or Organization): _____

Address: _____

City: _____State: _____ Zip: _____

I authorize the use or disclosure of the above named individual's health information as described below. Surgical Associates of West Florida is authorized to make this disclosure for the purpose of :

☐ Continuing Medical Care ☐ Personal Use
☐ Information for Insurance Co. ☐ Information for Attorney
☐ Other (please specify)_____

This authorization for release includes my personal health information consisting of:

☐ Initial Evaluation ☐ Operative Reports ☐ Medical Status
☐ Progress/Office Notes ☐ Discharge Summary ☐ Work Status
☐ Diagnostic Imaging Reports ☐ Laboratory Reports
☐ Other (please specify)_____

_____(initial) I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclose of the above information about or medical records of my medical condition to those persons or agencies named above. I understand that the disclosure of my personal health information as provided for herein will now constitute an authorized use or disclosure of my personal health information (PHI) pursuant to 45 C.F.R. § 164. I also understand, upon disclosure to the above recipient, my PHI will no longer be protected by the federal regulations governing the privacy of individual identifiable health information and that Surgical Associates of West Florida will not be able to restrict the disclosure of the my PHI by the intended recipient who is not affiliated with Surgical Associates of West Florida.

<u>This authorization will expire one year from the date of this request</u>. This authorization is not valid if not filled out completely.

_____ _____
Signature of Patient, Guardian, or Personal Representative Date

Social Security Number**:** _____ Date of Birth**:** _____

Surgical Associates of West Florida

Communication Release Form

Patient Name (Printed) _____

In regards to my protected health information, I authorize SAWF to:
Check all that apply:

☐ Call me at work. Phone #_____

☐ Call me at home and leave message on voice mail. Phone # _____

☐ Call my cell phone and leave voice mail. Phone # _____

☐ Send message to my e-mail. E-mail address _____

Speak to the following family member(s) or friend(s):

Name _____ Phone # _____

Name _____ Phone # _____

Name_____ Phone # _____

The above information can be changed at any time in writing by sending a letter to:

Surgical Associates of West Florida
1840 Mease Drive, Suite 301
Safety Harbor, FL 34695

Patient Signature _____ Date_____

IMPORTANT NOTICE – PLEASE READ

Surgical Associates of West Florida

Surgical Assistants

What is a surgical assistant?
In almost every surgery there is a need for an assistant. Most of the surgeries performed by our physicians are complex in nature and require more than one pair of hands. Your physician will choose an appropriate assistant for your surgery.

Will my insurance cover the surgical assistant charges?
All surgery charges will be billed to your insurance carrier. Sometimes the assistant may not be contracted with your insurance company and therefore, you may have additional costs. Please understand that should your insurance deny payment on a surgical assist, you will be held responsible for the unpaid balance.