

## **PARKSIDE SURGERY CENTER**

PLEASE BE ADVISED THAT \_\_\_\_\_ M.D. OWNS INTEREST IN PARKSIDE SURGERY CENTER, 2731 PARK ST. JACKSONVILLE, FL 32205.

YOU ARE ENTITLED TO OBTAIN THE SERVICES FOR WHICH YOU REFERRED TO PARKSIDE SURGERY CENTER AT THE LOCATION OF YOUR CHOICE.

### **ESTIMATES OF COPAYMENT/COINSURANCE**

PLEASE NOTE THE FEES ARE ESTIMATES ONLY. SHOULD YOUR PHYSICIAN PERFORM DIFFERENT OR ADDITIONAL PROCEDURES, THE CHARGES WILL BE ADJUSTED ACCORDINGLY.

DESCRIPTION

PT LABEL

### **COPAYMENT/CO-INSURANCE**

\$ \_\_\_\_\_

THE PHYSICIAN FEES FOR PROCEDURES PERFORMED AND THE ANESTHESIA SERVICE ARE BILLED SEPERATELY. IN SOME CASES A LAB FEE AND/OR PATHOLOGY FEE WILL BE ALSO INCURRED AND ARE BILLED SEPARATELY FROM THE FACILITY FEE.

### **ACKNOWLEDGEMENT BY PATIENT**

I ACKNOWLEDGE THAT THE ABOVE INFORMATION HAS BEEN DISCLOSED TO ME BY PARKSIDE SURGERY CENTER STAFF. I ACKNOWLEDGE THAT I RECEIVED THE ABOVE ESTIMATE OF FEES AND DESCRIPTION OF SERVICES AND SUPPLIES (IF APPLICABLE), I UNDERSTAND THAT THESE ARE ESTIMATES ONLY.

## **TURN OVER AND COMPLETE**

PATIENTS BILL OF RIGHTS AND RESPONSIBILITIES & PRIVACY PRACTICES.  
I HAVE READ AND RECEIVED A COPY OF MY “PATIENTS BILL OF RIGHTS AND RESPONSIBILITIES AND NOTICE OF PRIVACY PRACTICES.”

STATE OF FLORIDA REPORTING REQUIRMENT

THE STATE OF FLORIDA REQUIRES HEALTH CARE PROVIDERS TO COLLECT AND REPORT PATIENT DEMOGRAPHIC INFORMATION QUARTERLY ONE REPORTABLE ITEM IS RACIAL CLASSIFICATION.

PLEASE CIRCLE THE APPROPRIATE CLASSIFICATION FROM THE FOLLOWING LIST PROVIDED BELOW:

- ASIAN/PACIFIC ISLANDER      AFRICAN AMERICAN      CAUCASIAN
- NATIVE AMERICAN      WHITE HISPANIC      BLACK HISPANIC
- NO RESPONSE

I HAVE REVIEWED AND AGREE TO THE ABOVE:

\_\_\_\_\_  
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY      DATE

\_\_\_\_\_  
WITNESS      DATE