❑ **AdventHealth Surgery Center Ormond Beach**
❑ **AdventHealth Surgery Center Port Orange**

DISCLOSURE STATEMENT

The Center for Medicare and Medicaid Services and the State of Florida requires that our Center inform you both verbally and in writing of the following information:

ADVANCE DIRECTIVE:
You have the right to participate in your own health care decisions and to make informed decision regarding your care at our Center.
It is the policy of this Center that, regardless of the contents of any advance directives/living will or instruction from a health care surrogate, patient representative, or attorney, the Center will always attempt to resuscitate a patient and transfer that patient to an acute health care facility in the event of deterioration. A copy of your advance directive will be sent to the acute care facility where your directive will be honored according to your wishes.

If you do not agree with the Center policy, you must address this issue with your physician or anesthesia provider prior to signing this form.

If you have an existing advance directive/living will, please bring a copy of it on the day of surgery/procedure for our files. If you do not have an Advance Directive, the Center will provide you with Florida State forms upon your request.

I have provided the Center with a copy of my Advance Directive	❑ Yes	❑ No
I request that the Center provide me with Advance Directive Forms	❑ Yes	❑ No
Florida Advance Directive Forms were given to patient if requested	❑ Yes	

The following applies to Advance Directives in the State of Florida:

- The State of Florida has no legal requirement that an advance directive is completed.
- Forms completed in other States will be honored in Florida.
- If a person has not made an advanced directive, a court appointed guardian, their wife or husband, their adult child, their parent, their adult sibling, an adult relative, or a close friend may make a decision about their healthcare.
- Florida law provides samples of each of the following forms:
  - A living will
  - A healthcare surrogate.
  - Anatomical donation

PATIENT GRIEVANCES
Should you, your representative, or your healthcare surrogate have a complaint or concern about the care you receive at our facility, please contact Victoria Rioux, the Center Administrator, by telephone or in writing at the following Center's contact information:

AdventHealth Surgery Center Ormond Beach
550 Memorial Circle- Suite G
Ormond Beach, FL 32174
(386) 271-7105

AdventHealth Surgery Center Port Orange
1185 Dunlawton Ave- Suite 100
Port Orange, FL 32127
(386) 777-7151

We take all complaints and grievances seriously and it is this Center's policy to investigate all complaints and respond to you, your representative, or healthcare surrogate within seven days of our receipt of your grievance. We are also required to notify you in writing and therefore you, your representative, or healthcare surrogate will receive a letter when final investigation is completed that will inform you, your representative or healthcare surrogate of the results and resolution of the investigation.

You may also contact the AdventHealth Daytona Beach, AHCA, Medicare Ombudsman or AAAHC. Their contact information is located on the last page of the Patient's Rights and Responsibilities that you have received.

HEALTH RELATED DATA

The State of Florida requires that all facilities provide the public and patients with the website to obtain statistical and quality measures data that are submitted by the facilities.
The website is www.Floridahealthfinder.gov

NON-DISCRIMINATION

The Federal Affordable Care Act, Section 1557, prohibits discrimination or refusal of treatment based on race, color, national origin, sex, age, or disability.
If you feel that you have been subject to discrimination in healthcare or health coverage, you may file a complaint of discrimination under Section 1557 of the Affordable Care Act. You can go to the Office of Civil Rights' (OCR) website at www.hhs.gov/ocr to file a complaint or to request a complaint package. You can also call OCR at (800) 368-1019 or (800) 537-7697 (TDD) to speak with someone who can answer your questions and guide you through the process. OCR's complaint forms are available in a variety of languages on their website.

FINANCIAL DISCLOSURES

The State of Florida requires that we provide you with a list of financial disclosures and the Center's website. These have been provided to you in a separate document.

DISCLOSURE OF OWNERSHIP

The Center for Medicare and Medicaid Services and the State of Florida requires that our Center inform you of the ownership of the Center. The Centers are owned by AdventHealth Daytona Beach.

PATIENTS RIGHTS AND RESPONSIBILITIES

The Center for Medicare and Medicaid Services and the State of Florida requires that our Center informs you both verbally and in writing of your rights as a patient in advance of your procedure in a manner in which you understand.

- This Center acknowledges these rights without regard to sex or cultural, economic, educational, or religious background or the source of payment for care and without being subjected to reprisal.
- You have the right to considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
- A set of Patient's Rights and Responsibilities were provided to me and are also posted in the lobby of the Center.

PROTECTED HEALTH INFORMATION: I hereby authorize the Center to provide the following persons with all medical data and information concerning my illness and procedure/surgery: ______________________________

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COMMUNICATION: The Center can communicate information to me via: ❑ Phone ❑ VM

I have read, fully understand and acknowledge receipt of this Disclosure Statement and any indicated other documents.

____________________	____________________	________	________
Print Name	Sign Name	Date	Time

____________________	____________________	________	________
Patient's Agent/Representative/Healthcare Surrogate	Relationship to Patient	Date	Time

______________________________	________	________
Witness	Date	Time