Florida Digestive Health Specialists

Dear Valued Patient,

Thank you for choosing Florida Digestive Health Specialists, LLP ("FDHS"). Our premier digestive health network is designed with you in mind, built through teamwork and collaboration. We are committed to exceeding your expectations as a trusted provider of digestive health services.

Please complete the enclosed forms prior to your appointment. If you have any questions or need assistance, do not hesitate to ask. On the day of your appointment, bring the completed forms along with a photo ID, your insurance card(s), and your copay, as well as any other patient responsibilities. We kindly ask that you arrive 15 minutes before your scheduled appointment to allow time for processing your paperwork. If you do not bring your ID, insurance card(s), or copay, we will need to reschedule your appointment. We ask that all patient financial responsibilities be settled at the time of service whenever possible.

We will contact you by phone or mail with your lab or test results, if necessary, within a reasonable timeframe. If you do not receive your test results within 10 to 14 days from the date of your service, please reach out to our office.

Thank you for choosing us for your digestive health needs.

Sincerely,
Florida Digestive Health Specialists, LLP

IMPORTANT NOTE: FDHS Policy - If you are unable to keep your appointment for any reason, please provide at least 24 hours' notice for office visits. Failure to do so will result in a charge of $50.00 to your account.

For procedure cancellations, a minimum of 72 hours' notice is required. If you do not provide this notice, a charge of $75.00 will be applied.

Florida Digestive Health Specialists

MR#_____

PATIENT INFORMATION FORM

Last Name: _____ First Name: _____Middle: _____

Preferred Name: _____

Pharmacy & Location: _____

Referred by: _____ Primary Care Physician_____

Reason for Today's Visit: _____

Date of Birth: ___/____/____ Sex: M or F SS#: _____-_____-_____

Race: □ American Indian/Alaska Native □ Black/African American □ White/Caucasian □ Asian

□ Hawaiian/Pacific Islander □ Other □ Unknown □ Declined

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown □ Declined

Preferred Language: _____ Marital Status: (circle) S M D W

Local Address: _____Apt #: _____

City: _____ State: _____ Zip: _____

Alternate Address: _____City: _____

State: _____ Zip: _____ If seasonal address, list dates:_____

□ Home Phone #: _____ □ Work Phone #: _____ □ Cell Phone #: _____

□ Email Address: _____

*After providing a phone number and an email address to contact you for our Patient Portal, please place a √ beside the best way to contact you.

Employer's Name: _____

I authorize FDHS to contact PATIENT at email address:_____

Persons to whom we may release information (Please select what type of information we may discuss with them by initialing the applicable blank(s)):

I authorize FDHS to share Patient **Medical** _____**Billing**_____ information with the following individual:

PRINT Name_____ Relationship to patient_____

I authorize FDHS to share Patient M**edical** _____B**illing**_____ information with the following individual:

PRINT Name_____ Relationship to patient_____

EMERGENCY CONTACT: _____Phone #: _____Relationship: _____

INSURANCE INFORMATION

Responsible Party (if different than Patient)

Last Name: _____ First Name: _____ Middle Initial: _____

Local Address: _____Apt #: ____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Phone: _____ Email: _____

Primary Insurance

Policy Holder's Name: _____ DOB: ____/____/____ Relationship to Patient: _____

Plan Name: _____ Group Name: _____Group #: _____

Member ID #: _____

Coverage Type: ___ Self ___Family dependent ___ Handicapped dependent ___Sponsored dependent ___ Injured plaintiff
___ Student ___ Part-time student ___Full-time student

Secondary Insurance

Policy Holder's Name: _____ DOB: ____/____/____ Relationship to Patient: _____

Plan Name: _____ Group Name: _____ Group #: _____

Member ID #: _____

Assignment and Authorization of Benefits: I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance company or me at any time in writing. I hereby authorize Florida Digestive Health Specialists to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to Florida Digestive Health Specialists (or the party who accepts assignment). I certify that the information I have reported concerning my insurance coverage is correct. I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for the payment of all services provided on my behalf or my dependents. I agree to pay any reasonable collection fees, including reasonable attorney fees necessary to collect my debt.

Patient or Responsible Party Signature: _____ Date: _____

Florida Digestive Health Specialists

Patient History Form

MR#		
Last Name	First Name, Middle Initial	Date of Birth
Primary Care Physician	Other doctors involved in your care:	

PLEASE DO NOT WRITE IN THE BOX BELOW. FOR OFFICE STAFF ONLY

Nurses / Doctors notes:

Tests or labs ordered today:

WHAT IS THE REASON FOR YOUR VISIT WITH US TODAY?

Chief Complaint:

HAVE YOU HAD OR BEEN DIAGNOSED WITH ANY OF THESE ISSUES IN THE PAST?

System	*Yes*	*No*	*Year*	*System*	*Yes*	*No*	*Year*	*System*	*Yes*	*No*	*Year*
CARDIAC				***NEUROLOGIC***				***EAR, NOSE, THROAT***			
High blood pressure				Seizures				Loose teeth			
Low blood pressure				Weakness				Nosebleeds			
Irregular heartbeat				Migraines				Deafness			
Chest pain				Previous stroke				***PSYCHOSOCIAL***			
High cholesterol				***MUSCULOSKELETAL***				Alcoholism			
Vascular disease				Muscle disease				Substance abuse			
Pacemaker											
RESPIRATORY				Arthritis				Depression			
Asthma				Neck pain				Anxiety disorders			
Pneumonia				Back pain							
Bronchitis				Blood disorder							
Chronic cough				**Type of blood disorder:**				**Please list below any other symptoms:**			
Hoarseness											
Tracheostomy											
COPD				Rash							
Tuberculosis				MRSA							
GENITOURINARY				Bruises							
Kidney disease				***OPHTHALMIC***							
Chronic renal failure				Blindness				***Diagnosed with Cancer? Please list:***			
Currently on dialysis				Cataracts							
Urine infection (UTI)				Glaucoma							
ENDOCRINE/METABOLIC				***BREAST***							
Diabetes TYPE I / TYPE II				Lumps							
Thyroid disorder				Cancer							

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING GASTROINTESTINAL AND HEPATIC SYMPTOMS RECENTLY?

System	*TODAY*	*In the past 2 months*	*PLEASE INDICATE IF THIS ISSUE HAS BEEN RESOLVED BY WRITING "RESOLVED," or you may explain.*
GASTROINTESTINAL			
Diarrhea			
Constipation			
Rectal bleeding			
Change in bowel habits			
Weight loss			
Dark stools			
Irritable bowel			
Crohn's disease			
Ulcerative colitis			
Trouble swallowing			
Nausea/Vomiting			
Heartburn			
Abdominal pain			
HEPATIC			
End-stage liver disease			
Cirrhosis			
Hepatitis			
Pancreatitis ACUTE/CHRONIC			

PAST GASTROINTESTINAL PROCEDURES:	**YES**	**NO**	**APPROXIMATE DATE OF PROCEDURE**	**WERE POLYPS FOUND?**	**ANY ABNORMAL FINDINGS PLEASE EXPLAIN:**
HAVE YOU HAD A COLONOSCOPY IN THE PAST?					
HAVE YOU HAD AN UPPER ENDOSCOPY (EGD)?					
Have you:	**YES**	**NO**	**APPROXIMATE DATE(s)**		
Had a blood transfusion?					
Donated blood?					
Do you have tattoos (year of oldest tattoo)					

Have you ever had any surgery or been hospitalized?____Yes ___No Problems with anesthesia?___Yes___No If yes, please list:	Surgeries	Dates	Hospitalizations other than surgery	Dates

Social History:	Alcohol: How many drinks per day?___Per week?_____Per month?_____ Do you currently use street drugs__Yes___No If yes, How often? _____ Have you ever used street drugs___Yes___No When did you quit?_____
Tobacco use: Please check one: Non-Smoker: _____ Current smoker_____ Former Smoker_____	Tobacco: How many packs per day?_____For how many years?____ At what age did you begin Smoking?_____Year quit _____
Please list any allergies, including environmental, medication, food, and reaction to previous blood transfusion.	

FAMILY HISTORY **Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions:**

Condition	*Relation*	*Living/Deceased?*	*Condition*	*Relation*	*Living/Deceased?*	*Condition*	*Relation*	*Living/Deceased?*
Colon/ Rectal Cancer No__Yes___			Kidney problems No _____Yes___			Heart disease No_ _____Yes__		
Stomach cancer No__Yes___			Ulcerative colitis No__Yes__			Crohn's disease No__Yes__		
Breast cancer No _____Yes___			Ovarian cancer No _____Yes___			Bleeding problems No__Yes___		

Please indicate in this section any issues we have not addressed on this form:

_____

_____

_____

_____

_____

*****Patients: please do not sign until the Medical Assistant has gone over this information with you*****

I_____agree that the information I have provided on this patient
Printed Patient Name
history form is accurate to the best of my knowledge. The Medical Assistant has reviewed the information with me in the room, and I agree that this information will become part of my permanent medical record.

_____ _____
Patient Signature Today's date

FOR OFFICE USE ONLY, PATIENTS PLEASE DO NOT WRITE BELOW THIS LINE

The above information has been reviewed and discussed with the patient **YES / NO**	Date reviewed	Staff name/Title	Signature
Patient refused**: YES / NO** **If Refused, Reason:**			

CONSENT FOR TREATMENT
COMMUNICATIONS CONSENT
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
AND
AUTHORIZATION FOR RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

1. CONSENT TO TREATMENT

I, the undersigned, acting on my behalf or as the legally authorized representative of _____ _____ (PATIENT) hereby consent to examination, diagnostic testing and treatment by Florida Digestive Health Specialists, LLP, and its employees and agents (together, FDHS). I understand that the physical examination may include a medically appropriate examination of my pelvic area, and/or rectum and I consent to such examination. I acknowledge that no guarantees have been made to me regarding the results of any examination, care or treatment provided by FDHS.

2. RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of my medical information, including protected health information, concerning my treatment to any third-party payor, including but not limited to health plans and insurers, Medicare, Medicaid, TRICARE and CHAMPVA for payment purposes.

Further, I authorize payment of any insurance or other benefits that may be made on my behalf by any party, including any health plan or insurer, Medicare, Medicaid and any other federal or state health care programs, directly to FDHS. I understand that this assignment of benefits does not relieve me of my obligation to pay FDHS for any charges not covered by this assignment or not paid by insurance or health care benefits.

I understand and agree, whether I sign as Agent or Patient, that I am responsible for and guarantee payment of any charges incurred for the services provided to PATIENT by FDHS. I further understand and agree that I will be responsible for payment of any deductible, co-payment or co- insurance amounts, or any charge that is not covered or paid by insurance, health care benefits or third-party payors.

I authorize FDHS to release PATIENT's medical information, including HIV testing and treatment information, to other parties (which may include providers, payors, business associates or other entities) for the purpose of treatment, payment or healthcare operations.

_____
Signature of Patient or Patient's Legal Representative

_____
Name of Patient's Legal Representative and relation to Patient

Date:_____

COMMUNICATIONS CONSENT

_____(initial) I authorize Florida Digestive Health Specialists (FDHS) to leave telephone messages for PATIENT that may contain medical information at the following number(s):

_____

_____(initial) I authorize FDHS to contact PATIENT at the following email address:

_____

_____(initial) I authorize FDHS to share PATIENT medical information with

_____(Name and Relationship)

3. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you are agreeing that you have received a copy of FDHS's Notice of Privacy Practices, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

_____
Signature of Patient or Patient's Legal Representative

_____
Name of Patient's Legal Representative and relation to Patient

Date:_____

_____
For Office Use Only:

I personally delivered the Notice of Privacy Practices to the above-named patient (or authorized representative of the patient). A written acknowledgement of receipt by the patient or representative was not obtained for the following reason(s):

_____

_____ _____
[Signature of Office Staff Member] [Date]

Name: _____

Florida Digestive Health Specialists

Communication Agreement Form

Dear Valued Patient,

Thank you for choosing Florida Digestive Health Specialists as your digestive health provider.

As a participant in your own care, it is your responsibility to ensure that there is a clear and open method of communication from our office to you. It is also your responsibility to make sure that this office always has a way to contact you to communicate test results and other important matters related to your medical care.

We may recommend/perform diagnostic studies that we feel are important to your well-being. These studies are to diagnose your ailment(s), define treatment strategies and to maintain your health. As with all diagnostic studies, at times we find results that, if undiagnosed or diagnosis is delayed, can result in death or a serious disability. Some of these studies will be at the time of an active issue, and other times it will be recommended for the future.

We attempt to contact every patient with results of diagnostic studies and reminders for follow-up issues. Ultimately, if you do not hear from us within 14 days about your test results, it is your responsibility to contact us.

By initialing below and signing this letter you agree to the following:

(Please initial each line)

1. Call our office two weeks after any diagnostic study, if we have not notified your with results. _____
2. Call our office again, for any issue, if we do not return your call. _____
3. Immediately notify our office of a change of address and/or contact telephone numbers. _____
4. Keep a written record of when your diagnostic studies are scheduled and notify our office if you cannot comply. _____
5. Keep a written record of your future follow-up needs, even if it is ten years in the future. _____

By signing this letter you are agreeing that the responsibilities and obligations outlined in lines 1 through 5 are important to your future health and that you will comply with these obligations.

Thank you for trusting us with your care.

_____

Patient Name Printed

_____ _____

Patient Signature Date

_____

Witness Name Printed

_____ _____

Witness Signature Date

F03-2/29/16

Florida Digestive Health Specialists

commonwell HEALTH ALLIANCE

Dear Patient,

We believe that patients and your caregivers should have easy access to your medical information, no matter where you receive care. That's why we're participating in CommonWell, a service that allows a network of healthcare providers to identify you, securely send and receive your medical information, and help ensure that you receive optimal care.

What is CommonWell?

A *free, secure service* offered by your doctor, so your health information can be available to you and your doctors regardless of where you've received care.

You simply need to enroll in the service with a driver's license and then confirm the other CommonWell network doctors you see. Don't worry if you don't have a government-issued picture ID; you can still register.

How do we use the health information we share through CommonWell?

- ***Better coordinate your care across different doctors*** — We'll provide and request to receive your information *where* and *when* it's needed for your healthcare provider to deliver the care you need as you move from doctor to doctor.
    - Only healthcare staff directly involved in your care will access your medical information shared through CommonWell.
- ***Support better care decision-making*** — With timely access to information from other healthcare providers you've seen, your doctors may be able to make better decisions about your health.
    - This information will only be used to help improve your care, and won't be shared without your permission or unless it's required by law.
- ***Deliver care more promptly and efficiently*** —With less time wasted on tracking down your test results and other health information, your healthcare providers can treat you more efficiently and spend less time on paperwork and more time on your care.
    - We do need your help in confirming the other doctors or hospitals you've visited when you enroll in CommonWell.
- ***Securely and confidentially*** — Your Protected Health Information ("PHI") will always be confidential and used to inform the CommonWell participating healthcare providers. We won't use your PHI for discriminatory purposes of any kind or to deny medical treatment.
    - You can opt-out of this service anytime by calling or visiting this doctor's office and asking them to unenroll you from CommonWell.

☐ Accept ☐ Decline

Patient Name _____ MR #_____

Patient Signature _____ Date_____

CommonWell Health Alliance

The CommonWell services are provided by the CommonWell Health Alliance trade association. We are devoted to the notion that patient data should be safely, securely, and immediately available to patients and doctors regardless of where care occurs to deliver better care. We are committed to fostering standards that make this possible, and in having health information technology companies build these capabilities into their systems—the results: higher quality, more timely, more cost-effective care that delivers better health outcomes. Some of the participating vendors are Allscripts, athenahealth, Cerner, CPSI, eClinicalWorks, Greenway, McKesson, and Sunquest. Please visit https://www.commonwellalliance.org/connect-to-the-network/commonwell-connected-products/ for a complete list of connected vendors.

MR#_____

FLORIDA DIGESTIVE HEALTH SPECIALISTS, LLP

FINANCIAL POLICY

Our practice strives to provide optimal care, and we want to ensure you fully understand our Financial Policy.

1. Payment for all co-pays, deductibles, and outstanding patient balances is due at the time of service. We accept cash, checks, and most major credit cards. A minimum charge of $25.00 will be assessed on all returned checks.
2. Please be advised that your insurance policy is a contract between you and your insurance company.
    a. Our providers participate with many insurance companies and other health plans. Our billing department files the claims and accepts the assignment of benefits on these claims. The insurance company pays Florida Digestive Health Specialists, LLP (FDHS) directly for all claims filed by our billing service.
    b. If we do not have a contract with your insurance company, you will be required to pay for the medical services provided at the time of your visit. However, we will provide you with a summary of your visit in the form of an itemized receipt. You can submit this itemized receipt to your insurance company for reimbursement if they cover such expenses. If your insurance company approves the charges, they will pay you directly.
3. Not all insurance companies cover all services. If your insurance company determines a service to be "non-covered," you will be responsible for the entire charge. Your payment is due upon receipt of a statement from our office.
4. If you provide incorrect or false information resulting in claim denial, you are responsible for unpaid claims and service charges.
5. We will bill your insurance company for services provided to you in a hospital setting. You are responsible for any balance due if your insurance company does not pay.
6. If the undersigned fails to pay for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection costs incurred, including but not limited to all reasonable collection fees and/or reasonable contingency fees added by a third party to the outstanding or referred balance.
7. We require 24-hour notice for office visits if you cannot keep your appointment for any reason. If you do not provide the required notice, your account will be charged a $50.00 no-show fee. If you do not give 72-hour notice that you are canceling your procedure(s), you will be charged a $75.00 no-show fee.
8. If the patient or responsible party fails to pay for services rendered under standard practices, such nonpayment will result in the patient/undersigned's provider and all providers of FDHS terminating their provider relationship with the patient/undersigned in accordance with applicable law. Any outstanding balances for services provided will be sent to a collection agency.

I have read and understand the FDHS Financial Policy and agree to be bound by its terms. I also understand and agree that FDHS may amend such terms occasionally.

_____ _____

Signature of Patient (or Responsible Party) Date

_____

Patient Name (Print)

_____ _____

Print Name of Responsible Party (Print) (if different from Patient) Witness

Florida Digestive Health Specialists

Florida Digestive Health Specialists, LLP- *NOTICE OF PRIVACY PRACTICES*

This Notice of Privacy Practices outlines how your medical information may be used and disclosed and how to access it. Please take the time to review it carefully. Remember, you can obtain a paper copy of this Notice upon request.

Patient Health Information

Your patient health information is protected and confidential under federal law, including details about your symptoms, test results, diagnosis, treatment, and related medical information, as well as your 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 without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide medical treatment or services. For example, nurses, physicians, and other treatment team members 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 healthcare 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 your health information for payment purposes. For example, we may need 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 record administration, evaluation of the quality of treatment, and assessment of the care and outcomes of your case and others like it.

Special Uses

We may use your information to send you appointment reminders, provide information about treatment alternatives, or offer other health-related benefits and services that interest you.

Other Uses and Disclosures

- We may use or disclose your health information without your consent for certain purposes as permitted by specific requirements.
- *Required by Law:* We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- *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 law enforcement officials require.
- *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 an armed forces member, we may release information as military command authorities require. We may also disclose information to correctional institutions or for national security purposes.

- *Research:* We may use or disclose information for approved medical research.
- *Workers Compensation:* We may release information about you for workers' compensation or similar programs providing benefits for work-related injuries or illness.

We will always ask for your written authorization before using or disclosing identifiable health information about you, except in certain situations. If you do choose to sign an authorization, you can revoke it later to stop any future uses and disclosures of your health information.

Individual Rights

You have the following rights concerning your health information.

Request Restrictions: You may request restrictions on specific 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 specific 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 information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect or 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 your health information for reasons other than treatment, payment, or healthcare operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information. We 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 reserve the right to change our policies at any time. Prior to making a significant change, we will update our notice and display the new notice in the waiting area and each examination room. You can also ask for a copy of our notice at any time. For further information about our privacy practices, please contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights or disagree with our decision about your records, you may contact the person listed below and send a written complaint to the U.S. Department of Health and Human Services. The **Contact Person** listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Compliance Officer:
Deanne DiPasqua
10920 Technology Terrace
Lakewood Ranch, FL 34211
Email: compliance@fdhs.com
Phone: 941-757-4810, ext. 323

Effective Date: The effective date of this Notice is September 18, 2019.
Revised Date: June 13, 2023.

Committee on Health Policy

CS/CS/HB 1175 — Transparency in Health Care

by Health and Human Services Committee; Health Care Appropriations Subcommittee; Rep. Sprowls and others (CS/SB 1496 by Appropriations Committee; and Senators Bradley and Gaetz)

The bill increases the transparency and availability of health care pricing and quality of service information to enable consumers to make informed choices regarding health care treatment. The Agency for Health Care Administration (AHCA) is required to contract with a vendor to provide a consumer-friendly, Internet-based platform that allows a consumer to research the cost of health care services and procedures. The AHCA is to select the vendor through a competitive procurement process.

Services and procedures will be grouped by a descriptive service bundle to facilitate price comparisons provided in hospitals and ambulatory surgery centers (ASC). Quality indicators for services at the facilities will also be made available to the consumer to assist with health care decision making.

Hospitals and ASCs are required to provide access to the searchable service bundles on their website. Consumers will be presented with the estimated average payment received, excluding Medicaid and Medicare, and estimated payment ranges for each service bundle, by facility, facilities within geographic boundaries, and nationally. The facility must disclose that this information is an estimate of costs and that actual costs will be based on services actually provided to the patient. Additionally, the facility must disclose the facility's financial assistance policies and collection procedures.

The hospital and ASC must notify prospective patients that other health care providers may provide services in the facility and bill separately from the facility. Furthermore, the prospective patient must be informed that these healthcare providers may or may not participate with the same health insurers or health maintenance organizations (HMOs) as the facility. Accordingly, the patient should contact the applicable practitioners to determine the health insurers and HMOs with which the practitioner participates as a network or preferred provider. The facility must provide contact information for the practitioners.

Insurers and HMOs are required to provide on their websites a method for policy holders to estimate their cost-sharing responsibilities by service bundle based on the insured's policy and known plan usage. These estimates shall include both in-network and out-of-network providers. Insurers and HMOs are also required to provide hyperlinks on their website to the AHCA's performance outcome and financial data.

Consumers may request personalized good faith estimates of charges for nonemergency medical services from hospitals, ASCs, and health care practitioners relating to medical services provided in the hospital or ASC. These good faith estimates must be provided to the consumer within 7 days after the consumer's request. The bill provides for a daily fine for non-compliance by

facilities and health care practitioners. The personalized estimate must also inform the patient about the health care provider's financial assistance policies and collection procedures.

A patient may also request an itemized bill or statement from the hospital and ASC after discharge. The requested itemized bill or statement must be provided within 7 days and be specific, written in plain language, and identify all services provided by the facility and any facility fees, as well as rates charged, amounts due, and the payment status. The itemized bill or statement must inform the patient to contact his or her insurer regarding the patient's share of costs. The facility must provide records to verify the bill or statement within 10 days after a request and respond to questions concerning the statement or bill.

The bill requires health insurers and HMOs that participate in the state group health insurance plan or Medicaid managed care to submit all claims data from Florida policy holders, with certain supplemental plan exceptions, to the vendor selected by the AHCA.

Each diagnostic-imaging center operated by a hospital but not located on the hospital grounds is required to post in the reception area prices charged to uninsured persons for the 50 most frequently provided services. The bill prohibits the AHCA from establishing an all-payor claims database or a comparable database without express legislative authority.

If approved by the Governor, these provisions take effect July 1, 2016.
Vote: Senate 34-1; House 116-1