Florida Gynecologic Oncology
Zoyla Almeida, M.D., F.A.C.O.G
4855 W. Hillsboro Blvd #B-13, Coconut Creek, FL 33073
P 954.420.9182 F 954.420.9184 www.floridagynonc.com

Pre-Op Clearance Instructions & Responsibility Patient Acknowledgement

Dr. Almeida's surgery scheduler has explained to me that I am required to obtain a pre-operative clearance for my scheduled procedure from my Primary Care Physician.

- I understand that it is **my responsibility to call** my Primary Care Physician and **schedule an appointment** **no later than 2 weeks prior to surgery.**

- I acknowledge that I have been given a copy of the Clearance Request form and I have provided Dr. Almeida's office with the name of my Primary Care Physician and they will fax the Pre-Operative Clearance request to that physician. Should I not have a Primary Care Physician I will obtain one and notify the office immediately so they may fax the clearance form to them.

- Pre-Operative **clearance blood work is acceptable up to one month in advance of my procedure.** Any blood work older than one month must be repeated. There are no exceptions.

I acknowledge that all of this has been explained to me in detail, that I understand that Pre-Operative Clearance is required before my procedure can take place, and that I am responsible for scheduling my appointment with my Primary Care Provider to obtain the required testing and clearance. **All medical clearances must be completed and received by Dr. Almeida's office 48 hours prior to the surgery.**

Patient Signature:

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Covid-19 Testing Protocol

- I understand that I must have a Covid-19 test no later than 5 days prior to my surgical procedure. After testing I will self-quarantine until the date of my surgical procedure.
- I understand that without a Covid-19 test, I must reschedule the surgical procedure.
- I understand that should my test come back positive my surgical procedure will be rescheduled after I self-quarantine for 14 days and re-test to ensure I am negative prior to surgery.

I have been informed that All Covid-19 tests will be done at the scheduled facility. The facility will contact me to schedule the appointment.

Patient Signature: ____________________________________

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Surgery Cost Instructions

Your surgery with Dr. Zoyla Almeida has been scheduled. Our office will contact your insurance company 2 weeks prior to your procedure to obtain the professional fees and any needed authorizations. The fees we check for are for Dr. Almeida only. We are not responsible for checking hospital or facility fees. The hospital/or facility will contact you within a week of surgery to notify you of their upfront costs.

It is your responsibility to be knowledgeable about your insurance coverage and to contact your insurance company to obtain your benefits for your surgery. You may have an out-of-pocket responsibility including coinsurance amounts, deductibles, or copays.

We will call you approximately one week prior to your surgery to collect any amounts due for Dr. Almeida's services. These fees are collected before the surgery and are payable up to the day before your scheduled surgery date. It is the policy of the office that these fees must be paid *before* your surgery.

The fee amount you are quoted for Dr. Almeida's services is the amount given to us from the insurance company when we call them. These fees may be more dependent upon what procedures Dr. Almeida needs to perform for you. If she is in surgery with you and determines another or different procedure is clinically indicated or medically necessary, this will affect the fee for her services. If this is the case, we will then bill you for the remainder of those charges.

Please be aware of your benefits and contact your insurance company so that you are knowledgeable about your coverage, deductible and any out-of-pocket responsibilities.

Patient Signature____ **Date**____________________

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Cancellation & Reschedule Policy

It is the policy of Florida Gynecologic Oncology and Robotic Surgery that all patients who schedule their surgical procedure must give us a notice of cancellation/rescheduling at least one week prior to the scheduled procedure.

Patients who cancel their scheduled procedure within one week of the surgical date (calendar week) will be charged a $250.00 cancellation fee.

Patients who wish to reschedule must do so within one week of the surgical date (calendar week).

I acknowledge that I have read the above statements and understand that if I intend to cancel my procedure for any reason, and I do not give Dr. Almeida's office at least one week's notice, that I will be responsible to pay the cancellation fee of $250.00.

Patient Signature: ___________________________

Date: ______________________________________

Surgery During COVID-19

Patient Authorization and Consent Form

On March 11, 2020, the World Health Organization declared the COVID-19 disease a pandemic. As a result, many hospitals and surgery centers put a hold on all elective and non-urgent procedures and surgeries. This was part of an effort to save personal protective equipment (PPE) for frontline healthcare workers treating COVID-19 patients.

In many areas of the country, there is enough PPE, and elective/non-urgent procedures and surgeries are resuming. However, there is still a risk for performing these procedures and surgeries during the COVID-19 pandemic. These risks include but are not limited to exposure to other patients, healthcare staff, and healthcare facilities.

More Facts

I understand that COVID-19 is very contagious. It is most likely spread by person-to-person contact. I understand that my doctor and his or her staff will follow all laws and recommendations from local, state, and national health officials. However, there are still risks of being infected with COVID-19 during a procedure or surgery. I agree to assume the risks, and I give permission for my doctor and the staff to perform a procedure or surgery on me.

Some patients have a higher risk of complications from COVID-19, including those with:

- asthma,
- chronic lung disease,
- serious heart disease or problems,
- chronic kidney disease,
- extreme obesity,
- a compromised or suppressed immune system,
- liver disease,
- pregnant,
- age 65 or older, or
- nursing home or long-term care facility residents.

Some risks are not yet known. I understand that if I have one or more of these conditions, I may have a higher chance for 1) getting COVID-19 and 2) health problems if I get COVID-19. I understand that these problems may be serious. I may have to be in the hospital for a long time and could even die.
I understand that possible exposure to COVID-19 before, during, or after my procedure or surgery may result in: a COVID-19 diagnosis, a long quarantine or self-isolation, more tests, being in the hospital, intensive care treatment, intubation/ventilator support, short-term or long-term intubation, other complications, and the risk of death. Also, after my elective/non-urgent procedure or surgery, I may need to go to an emergency room or a hospital for care. I have been given the option to wait until a later date to have my procedure/surgery.

I understand all of the risks, including but not limited to the potential problems related to COVID-19, and I would like to proceed with the procedure/surgery.

Consent to Treatment

_____________The first page of this consent form told you about COVID-related risks. If, after reviewing this form, you do not believe that you really understand the risks and choices, **do not sign the form until all questions have been answered.**

_____________I understand the facts provided to me on the first page of this consent form. I give my consent for elective/non-urgent procedures and surgeries. By signing below, I agree that staff/doctor has discussed the facts in this form with me, that no one has given me any guarantee, that I have had a chance to ask questions, and that all of my questions have been answered.

_____________________________________ ___________________

Signature of Patient or Responsible Party Date and Time

____

Relationship to Patient (if Responsible Party is not Patient)

_____________________________________ ____________________

Witness Date and Time