Patient Day of Surgery – Package of Forms

Includes:

- **Patient Rights & Responsibilities**
- **Statement of Limitation Regarding Advance Directives**
- **Patient Medication History**
- **Acknowledgement of Requirement for Responsible Adult to Remain on Premises**
- **Patient Communication Preferences Regarding PHI**
- **Patient Health History**

Patient Rights & Responsibilities

Patients Have the Right to:

- Receive access to equal medical treatment and accommodations regardless of race, creed, sex, national origin, religion or sources of payment for care.
- Be fully informed and have complete information, to the extent known by the physician, regarding diagnosis, treatment, procedure and prognosis, as well as the risks and side effects associated with treatment and procedure prior to the procedure.
- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice grievances regarding treatment or care that is (or fails to be) furnished.
- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.
- Receive the care necessary to regain or maintain your maximum state of health and if necessary, cope with death.
- Expect personnel who care for you to be friendly, considerate, respectful, and qualified through education and experience, as well as perform the services for which they are responsible with the highest quality of services.
- Be fully informed of the scope of services available at the Center, provisions for after-hours care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If you are unable to participate in those decisions, the patient's rights shall be exercised by your designated representative or other legally designated person.
- Make informed decisions regarding your care.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions including refusal of treatment or not following the instructions of the physician or Center.
- Approve or refuse the release of medical records to any individual outside the Center, or as required by law or third party payment contract.
- Express grievances/complaints and suggestions at any time.
- Access to and/or copies of your medical records.
- Be informed as to the Center's policy regarding Advance Directives/Living Will/Power of Attorney.
- Express those spiritual beliefs and cultural practices that do not harm or interfere with the planned course of medical therapy for the patient.
- Expect the Center to agree to comply with Federal Civil Rights Laws to provide interpretation for individuals who are not proficient in English.
- Have an assessment and regular assessment of pain.
- Education of you and your family, when appropriate, regarding your roles in managing your pain.
- To change providers if other qualified providers are available.

If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf. If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state laws may exercise the patient's rights to the extent allowed by state law.

Patients Responsibilities:

- Bring health insurance card(s)
- Bring government issued photo identification
- Bring form of payment (if applicable)
- Be certain to bring documentation of Guardianship or Power of Attorney, POA (if applicable)
- Be considerate of the rights of other patients and personnel and assist in the control of noise, number of visitors, eating and other distractions.
- Respect the property of others and the Center.
- Report whether you clearly understands the planned course of treatment and what is expected of you.
- Keep appointments and, when unable to do so for any reason, notify the Center and physician.
- Provide caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, and medications.

- Report unexpected changes in the your condition, or any other health matters.
- Observe prescribed rules of the Center during your stay and treatment and, if instructions are not followed, forfeit the right to care at the Center.
- Promptly fulfill your financial obligations to the Center.
- Identify any patient safety concerns.

Advance Directives Notification

- In the State of Arizona, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Surgery Center of Gilbert respects and upholds those rights.
- Arizona State Law (CFR-416.50 Conditions for Coverage) permits ambulatory surgery centers to decline to implement certain elements of your Advance Directives based on our conscience and commitment to patient care.
- Unlike in an acute care hospital setting, the Surgery Center of Gilbert does not routinely perform "high risk" procedures. While no surgery is without risk, most procedures performed in this Center are considered to be of minimal risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after your surgery.
- Therefore, it is our policy, regardless of the contents of any Advance Directives or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during the your treatment at this Center, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directives, or health care Power of Attorney. Your agreement with this Center's policy will not revoke or invalidate any current health care directive or health care power of attorney.
- If you wish to complete an Advance Directive, copies of the official state forms are available at our Center.
- If you do not agree with this Center's policy, we will be pleased to assist you in rescheduling your procedure.

Disclosure of Ownership

Surgery Center of Gilbert is proud to have a number of quality physicians invested in our Center. Their investment enables them to have a voice in the development and administration of policies for our Center. This involvement helps to ensure the highest quality of surgical care for our patients.

Your physician**,** ____ **does /does not *(circle as appropriate)*** have a financial interest in this Center.

Responsible Party

You must be accompanied by a responsible adult to provide transportation home after discharge from the Center and stay with you for the first 24 hours following your procedure. This individual must be present at the Center at all times. The responsible party for children under 18 must be a parent or guardian.

By signing this document, I acknowledge that I have received, read and understood this information prior to my surgery/procedure.

____

Patient / Patient Representative Signature *Date*

Patient Complaint or Grievance

To report a complaint or grievance, you can contact the Center Administrator by phone or mail: Surgery Center of Gilbert, 6003 E. Baseline Rd., Mesa, AZ 85206. 480.641.6500

Complaints and grievances may also be filed through:

- Arizona Department of Health Services, Division of Licensing Services, 150 N. 18th Ave., Suite 450, Phoenix, AZ 85007-3245. 602.354.3030.
- State of Arizona, CMS Regional Office, DHHS/CMS/DSC/CLIA, 90 7th St., Suite 5-300 (SW), San Francisco, CA 94103-6707, 415.744.3696.
- Accreditation Association for Ambulatory Health Care, 5250 Old Orchard Rd., Suite 200, Skokie, IL 60077. 847.853.6060
- Medicare beneficiaries may receive information regarding their options under Medicare and their rights and protections by visiting the Office of the Medicare Beneficiary Ombudsman online at

Statement of Limitation Regarding Advance Directives

Note a revocation of advance directives or medical power of attorney

All patients have the right to participate in their own health care decisions and to make advance directives, or to execute power of attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This Surgery Center respects and upholds those rights.

However, unlike an acute care hospital setting, the Surgery Center does not routinely perform high-risk procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to your risks, expected recover and care after your surgery.

Therefore, it is our policy, regardless of the contents of any advance directives or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directives or health care power of attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current health care directive or health care power of attorney.

If you do not agree to this policy, we will be pleased to assist you in rescheduling the procedure.

Please check the appropriate box to answer the following question: ***Have you executed an advance directive, a living will, or a power of attorney that authorizes someone to make health care decisions for you?***

☐ ***YES.** I have an advance directive, living will or health care power of attorney and have furnished a copy to the Surgery Center of Gilbert.

☐ **YES**. I have an advance directive, living will or health care power of attorney but **HAVE NOT** furnished a copy to the Surgery Center of Gilbert.

☐ **NO.** I do not have an advance directive, living will or health care power of attorney.

☐ I would like to receive information on advance directives.

* If you checked the first YES box above, please provide us with a copy of that document to place in your medical record.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have indicated I would like to receive additional information, I acknowledge receipt of that information.

By: ____

Patient Signature

Patient Last Name:	Patient First Name:	Date:

If consent to the procedure is provided by anyone other than the patient, this form must be signed below by the person providing consent or authorization.

I acknowledge that I have read and understand the policy and contents, and agree to the policy as described.

By:____

Signature Print Name

Relationship to Patient:

☐ Court Appointed Guardian ☐ Attorney in Fact

☐ Health Care Surrogate ☐ Other ______________________

surgery center of GILBERT

MEDICATION RECONCILLIATION

*Please write all medications and allergies on this form. Unfortunately attached lists cannot be accepted. Thank you

List all allergies/reactions to medications(prescription and over the counter),environmental, foods and latex

Allergy	Reaction	Verified by:

List all Prescription Drugs and Over-the-Counter Medications, Including Dietary Supplements, Vitamins & Herbal Medications

Please resume all medications as directed by the prescribing physician

Drug Name and Dose	Frequency	Reason for Medication

When can I have my next dose?

DRUG:	Reason for this medication:	TIME:

Your Physician may have provided you with a prescription you will need to fill. Further information regarding medication administration, side effects and /or adverse reactions will be provided by physician or dispensing pharmacy.

Discharge Medication- Doctor/Nurse Use Only (this is not a prescription)

Drug Name & Dose	Frequency	Reason for Medication

Patient or Guardian Signature Date Patient label

Discharge RN signature Date

Acknowledgement of Requirement for Responsible Adult to Remain on Premises

Patient Name: ____

I acknowledge that as the responsible adult providing transportation after discharge from the Surgery Center of Gilbert, I have been advised to remain on premises at the Surgery Center. I will remain on the premises until the patient I am providing transportation has been discharged.

______________________________	______________________________
Printed Name of Responsible Adult	Relationship to Patient
	______________________________
	Responsible Adult Cell Phone Number
______________________________	______________________________
Signature	Date

Please provide the name and number of the person that will be monitoring you for the 24 hours required after discharge.

☐ Same as above

______________________________	______________________________
Name	Phone Number

If you and your responsible adult will be traveling using an outside transportation company, please provide their name and number below:

______________________________	______________________________
Name	Phone Number

Patient Communication Preferences Regarding PHI

Telephone Communication Preferences:

Home Phone ________________________________

Work Phone ________________________________

Mobile Phone ________________________________

Other ________________________________

Place Patient Identification Label Here

Email Communication Preferences:

Email Address ________________________________

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Surgery Center of Gilbert or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service, or leave a voice message on an answering device. If an email address has been provided, the Surgery Center or one of its legal agents may contact me with an email notification regarding my care, surgery center services or my financial obligation.

Mail Communication Preferences
May we send mail to your home address? If no, please print an alternative mailing address:

____

Other than you, your insurance company and health care providers involved in your care, who can we talk with about your health care information? Check all that apply:

Name	Telephone
☐ Spouse ________________________	________________________
☐ Caretaker ________________________	________________________
☐ Child ________________________	________________________
☐ Parent ________________________	________________________
☐ Other ________________________	________________________

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

____

Patient or Personal Representative Signature　　　　　　　　　　Date

________________________________　　　　________________________________

Printed Name　　　　　　　　　　Relationship to Patient

Patient Health History

Name ____

All allergies (including tape, Betadine, latex, food, medications and environmental). Reactions? ____

____

Previous Surgeries: ____

Any problems with anesthesia for you or your family? ____

Have you or anyone in your family been diagnoses with MRSA, VRE or C.Diff?
☐ No ☐ Yes. Date & treatment ____

Please check all that apply to the patient only:

For Children Only
☐ Reactive Airway Disease
☐ Full term / Premature birth
☐ Immunizations current Y / N
☐ Autism
☐ Chrosomal Disorder
☐ Downs Syndrome
☐ Loose Teeth

Respiratory
☐ Pneumonia/ Valley fever/ TB Chronic or frequent cough
☐ Sleep Apnea/ CPAP machine
☐ Shortness of breath/ Oxygen use ___________liters
☐ COPD - Bronchitis/ Asthma/ Emphysema

Cardiovascular
☐ Pacemaker/ Defibrillator
☐ Chest pain / Angina
☐ Irregular heart rate
☐ Swelling of hands, feet, or ankles
☐ Rheumatic Fever
☐ High blood pressure
☐ Heart Murmur, Mitral valve prolapse (MVP)
☐ Heart Attack / Congestive Heart Failure
☐ Other: ____________________________________

Endo
☐ Diabetes - diet/meds/insulin controlled
☐ Thyroid disease

Skeletal
☐ Back or neck problems, fractures
☐ Arthritis / Rheumatism

Neuro
☐ Fainting spells / seizures
☐ Tremors / Restless Leg Syndrome
☐ Weakness or paralysis of extremity / Stroke
☐ Numbness or tingling of extremity
☐ Anxiety/ Depression
☐ Often or severe headache / Migraines
☐ Memory loss/Alzheimer's disease/Dementia
☐ Parkinson's Disease

Other
☐ Glaucoma
☐ Alcohol use, how often ____________________________________
☐ Smoking, how much/how long? ____________________________________
☐ Street drugs, what & how often? ____________________________________

GI / GU
☐ Liver or gallbladder problems
☐ Esophagus or colon problems
☐ Jaundice / Hepatitis
☐ Hiatal hernia / Acid reflux
☐ Kidney / Bladder / Prostrate problems
☐ Other ____________________________________

Skin
☐ Lesions / cancer / bruises
☐ Rashes / hives / eczema / psoriasis

Reproductive
☐ Pre / post menopausal
Date of last menstrual period ____________________________________
☐ Breast cancer / IIV or B/P restrictions
☐ Pregnant or breastfeeding?

Hemo
☐ Anemia / bleeding tendencies / blood transfusions
☐ Phlebitis / blood clots
☐ Blood diseases / HIV

Prosthesis / Joint Replacement
☐ Dentures / partial plates, upper or lower
☐ Hearing aids, right or left
☐ Glasses or contacts
☐ Metal implants, where? ____________________________________

Notes ____

Patient signature: History is correct to the best of my knowledge ____
☐ No changes in medical history
History reviewed / RN signature: ____