

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Experior Surgery Center the benefits payable to me, but not to exceed the balance of the charges for this period of hospitalization.

AUTHORIZATION: I hereby authorize release of any medical information necessary to process this claim. I authorize XYZ Surgery Center to complain to the insurance commissioner for any reason. I further authorize the release of medical information to those healthcare facilities and/or physicians who may be responsible for the patient's follow-up care. I understand that it may be necessary to test the patient's blood while in the Surgery Center to protect against possible transmission of blood-borne diseases such as Hepatitis-B or Acquired Immune Deficiency Syndrome (AIDS). If, for example, a Surgery Center employee or physician is stuck by a needle while drawing blood or sustains a scalpel injury, I understand and consent that the patient's as well as the employee's or physician's blood will be tested (as appropriate). I further understand that the blood will not be routinely tested for these diseases and the results of any testing will be kept confidential in accordance with the state law.

FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to Experior Surgery Center for any amount not covered by this authorization. Within 48 hours, a claim will be filed with my insurance carrier. I will be notified when final action (payment, rejection, etc.) by my insurance carrier has been received by the Surgery Center. Payment will be expected within 10 days of that notice. In the event that this account is placed with an attorney or collection agency, the undersigned is responsible for collection fees, reasonable attorney's fees and court costs.

NOTE: YOU WILL BE BILLED SEPARATELY FOR SERVICES PROVIDED BY YOUR SURGEON AND/OR ANESTHESIOLOGIST.

Date: _____ **Signature:** _____ **Relationship to Patient:** _____
(PARENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR)

P A T I E N T	SURGERY DATE	PATIENT'S NAME (FIRST-MIDDLE-LAST)		S	BIRTHDATE	AGE	SSN
	STREET ADDRESS		CITY, STATE		ZIP CODE	TELEPHONE NUMBER	COUNTY
	NOTIFY IN CASE OF EMERGENCY		TELEPHONE NUMBER	SURGEON		REFERRING PHYSICIAN	
1 S T R E S P P A R T Y	1ST RESPONSIBLE PARTY'S NAME (FIRST-MIDDLE-LAST)		TELEPHONE NUMBER		PRIMARY INSURANCE DEDUCTIBLE _____ MET: Y/N		COVERAGE %
	STREET ADDRESS		CITY, STATE		PATIENT RESPONSIBILITY		OUT OF POCKET
	ZIP CODE	SOCIAL SECURITY NUMBER	RELATIONSHIP		MAXIMUM COVERAGE		
	EMPLOYER		OCCUPATION		SECONDARY INSURANCE DEDUCTIBLE _____ MET: Y/N		COVERAGE %
	EMPLOYER'S ADDRESS				PATIENT RESPONSIBILITY		OUT OF POCKET
	CITY, STATE, ZIP CODE				MAXIMUM COVERAGE	NEXT OF KIN (NAME + PHONE NUMBER)	
ACCIDENT? YES NO		ACCIDENT DATE	ACCIDENT TYPE: CIRCLE ONE WORK AUTO OTHER IF OTHER, DESCRIBE:				MEDICAL RECORD NUMBER
I N S U R A N C E	P R I M	SUBSCRIBER'S NAME (FIRST-LAST)		R	INS. CODE	INSURANCE CARRIER	EXT. REFERENCE/PRE-CERT/AUTH NUMBER
		INSURANCE CARRIER'S ADDRESS				GROUP NUMBER	POLICY NUMBER
	S E C O N D	SUBSCRIBER'S NAME (FIRST-LAST)		R	INS. CODE	INSURANCE CARRIER	EXT. REFERENCE/PRE-CERT/AUTH NUMBER
		INSURANCE CARRIER'S ADDRESS				GROUP NUMBER	POLICY NUMBER

ADMISSION SHEET

Allergies Yes No To what _____ Reaction _____

Latex sensitivity/allergy Yes No Communicable Disease Yes _____ No

Time of arrival Yes Accompanied by responsible adult

Transportation Center Family Member Sensory Impairment Yes _____ No

Nothing by Mouth
 • 8 hours pre-op
 • Medications with sips of water
 • No lifesavers/gum/candy

Financial responsibility
 • secondary insurance
 • private pay
 • method of payment cash check credit card

Clothing
 • Comfortable
 • Loose fitting (buttoned top)

Bring list and dosage of current medications: Yes No Signature: _____

POST-OPERATIVE PHONE CALL

Do Not Call _____ Patient Signature _____ May we leave a message on answering machine or with a family member? <input type="checkbox"/> Yes <input type="checkbox"/> No Patient Signature _____	Patient Home Phone # _____ Or Where you can be reached tomorrow # _____
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PROCEDURE: _____ DATE: _____ SURGEON: _____

1st Attempt DATE _____ TIME _____ CALLED BY _____ MSG / BUSY / NO ANS

2nd Attempt DATE _____ TIME _____ CALLED BY _____ MSG / BUSY / NO ANS

3rd Attempt DATE _____ TIME _____ CALLED BY _____ MSG / BUSY / NO ANS

Information Obtained From: Patient / Parent / Spouse / Other _____

Drainage Y / N Location _____ Amount _____

Dressing Y / N Dry Y / N Intact Y / N

Pain Y / N Location _____ Degree Mild Moderate Excessive

Pain Medication Y / N Effective Y / N If no, explain _____

Nausea/Vomiting Y / N Diet Tolerated Y / N

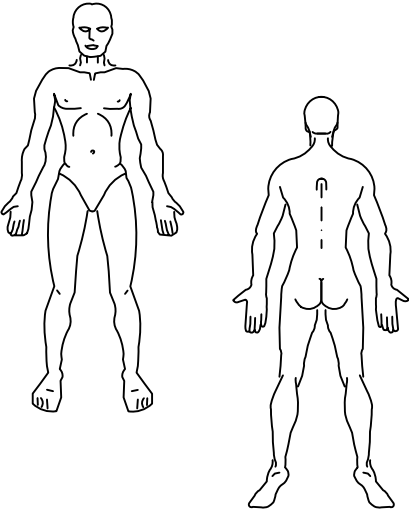
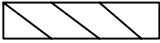
Any Fever (100.9) Y / N

Doing Well

What are your concerns/comments related to your experience? _____

Unable to reach by phone _____ Signature: _____

PRE-OPERATIVE QUESTIONNAIRE

Preoperative Diagnosis _____ _____ Postoperative Diagnosis _____ Procedure _____ _____ <input type="checkbox"/> Scheduled <input type="checkbox"/> Unscheduled Rm _____ Wound Class 1 2 3 4 Surgeon _____ Assistant _____ Scrub _____ Circulator _____ Observer _____		ID Verification: <input type="checkbox"/> Medical Record <input type="checkbox"/> Bracelet <input type="checkbox"/> Verbally <input type="checkbox"/> Pre-op Assessment Review <input type="checkbox"/> Consent Verified <input type="checkbox"/> Operative Site Verified Allergies: _____ In Room _____ Anesthesia Start _____ Procedure Start _____ Procedure End _____ Leave OR _____ To _____ Per _____
Anesthesia Type <input type="checkbox"/> Sedation <input type="checkbox"/> Local <input type="checkbox"/> Regional <input type="checkbox"/> Mac <input type="checkbox"/> Gen By _____ <input type="checkbox"/> MDA <input type="checkbox"/> CRNA	<input type="checkbox"/> Non-tissue Procedure Specimen <input type="checkbox"/> NA Cultures <input type="checkbox"/> NA Other _____	
Position _____ by _____ <input type="checkbox"/> Supine <input type="checkbox"/> Beach Chair <input type="checkbox"/> Lateral <input type="checkbox"/> Rt. <input type="checkbox"/> Lt. <input type="checkbox"/> Supine w/ Kneeholder FOB <input type="checkbox"/> Padding (P) <input type="checkbox"/> Prone <input type="checkbox"/> Lithotomy Position Aides: Cane Stirrups Allen Stirrups Vac Sac Gel Pad Blanket Off Leg Holder		
ESU <input type="checkbox"/> NA Coag. _____ # _____ Cut _____ Bipolar _____ Ground Pad (G) Site OK <input type="checkbox"/> removal <input type="checkbox"/> Placed By _____ Site Shaved Y N Other _____	EBL <input type="checkbox"/> Minimal _____ Counts <input type="checkbox"/> NA <input type="checkbox"/> Sponges Correct <input type="checkbox"/> Needles Correct X's _____ By: _____	
Tourniquet (T) <input type="checkbox"/> NA # _____ set@ _____ mm Hg Left ↑ _____ ↓ _____ ↑ _____ ↓ _____ Right ↑ _____ ↓ _____ ↑ _____ ↓ _____ <input type="checkbox"/> Site Padded <input type="checkbox"/> Site Ok <input type="checkbox"/> removal Placed By _____ Other _____	Dressings _____ _____ <input type="checkbox"/> Splint/Cast Type _____ Catheters <input type="checkbox"/> NA _____ Drains <input type="checkbox"/> NA _____ Packing <input type="checkbox"/> NA _____ <input type="checkbox"/> Radiation Safety Measures Taken <input type="checkbox"/> C-Arm by: _____	
Irrigation <input type="checkbox"/> NA Type _____ _____ Amount _____	Area Prepped  Site Shaved Y N Prep Solution _____ Skin Condition <input type="checkbox"/> Warm / Dry / Intact Other _____ Skin Condition unchanged post-op <input type="checkbox"/> Safety Strap WW <input type="checkbox"/> NA Padded Armboards <input type="checkbox"/> Rt. <input type="checkbox"/> Lt. _____ Additional Comments: _____ _____ _____	

Signature: _____

INTRAOPERATIVE RECORD

Pre-Op Time In: _____ Pre-Op Time Out: _____

PRE-OPERATIVE QUESTIONNAIRE

VITALS	K	GLU	EKG			B/P	TEMP	PULSE	RESP	HEIGHT	WEIGHT	SAO2
1 CONSENT FOR SIGNED/ DATED/ WITNESSED <input type="checkbox"/>						MEDICATIONS GIVEN						
2 SPECIAL CONSENT RELEASES SIGNED/ DATED/ WITNESSED <input type="checkbox"/>						DRUG& DOSE	TIME	METHOD				
3 HISTORY, PHYSICAL COMPLETED <input type="checkbox"/>						1						
4 I.D. BAND <input type="checkbox"/> OPERATIVE SIDE: _____						2						
5 LAB <input type="checkbox"/> TRANSPORTATION HOME <input type="checkbox"/>						3						
6 HEARING AID <input type="checkbox"/> CONTACT LENSES <input type="checkbox"/> DENTURE <input type="checkbox"/>						ALLERGIES: _____						
7 MAKE-UP <input type="checkbox"/> PROTHESIS <input type="checkbox"/> NAIL POLISH <input type="checkbox"/>						_____						
8 LANGUAGE BARRIER						_____						

NURSES NOTES

INTRAVENOUS THERAPY

SOLUTION	CATHETER	GAUGE

PRE-OPERATIVE QUESTIONNAIRE

DO YOU OR HAVE YOU EVER SUFFERED FROM :

	YES	NO
1. LUNG TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>
2. HIGH OR LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>
3. HEART TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>
4. LIVER PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
5. KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>

IF YES, PLEASE DESCRIBE _____

6. DIABETES FBS _____ YES NO

7. DATE OF LMP _____

8. DO YOU DRINK ALCOHOLIC BEVERAGES?
IF YES, DO YOU DRINK DAILY? YES NO

9. DO YOU SMOKE? HOW MANY PPD? _____ YES NO

12. PLEASE LIST ALL MEDICATIONS INCLUDING HERBAL, OTC, VITAMINS, ETC.

13. ARE YOU EXPERIENCING PAIN? YES NO

PLEASE RATE 0-10 _____

HOW DO YOU TREAT YOUR PAIN _____

14. DO YOU USE RECREATIONAL DRUGS? YES NO

Valuables & Personal Items	YES	NO	Locker Number	Family
IF	<input type="checkbox"/>	<input type="checkbox"/>		

NPO

HAVE YOU HAD ANYTHING TO EAT SINCE MIDNIGHT? YES, WHAT AND WHEN?

10. HAVE YOU EVER HAD ANY PREVIOUS SURGERIES OR ADVERSE REACTIONS FROM ANESTHESIA?

11. HAVE YOU OR ANY FAMILY MEMBER HAD AN UNUSUAL REACTION TO ANESTHESIA? PLEASE DESCRIBE:

I am responsible for all valuables above and all other personal property in my/his/her possession during my/his/her entire hospitalization.

PT Signature _____

RN Signature _____

PRE-OPERATIVE TEACHING AND NURSING CARE PLAN FOLLOWED

 PATIENT OR GUARDIAN

 NURSING

PRE-OP/ASSESSMENT/ANESTHESIA QUESTIONNAIRE

The anesthetic procedures, alternative types of anesthesia, benefits, risks and potential complications were explained. The patient (or guardian) understands and accepts.

ANESTHESIOLOGIST/C.R.N.A.

DATE

TIME

Pre-Op Medications

Vital Signs: Time: BP: HR: R: T: Ht: Wt:

Proposed Surgery	Proposed Anesthesia <input type="checkbox"/> GA <input type="checkbox"/> Regional <input type="checkbox"/> GA/MAC	Post Op <input type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Floor
Diagnosis:		

Drug Allergies: Nil

Previous Surgery Nil Old Chart: Nil N/Avail Checked

Previous Intubation: Nil Easy Diff N/A

Anesthetic Family Hx: Nil

Past Illnesses Nil

Current Meds Nil

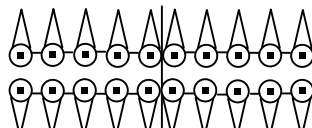
Physical Exam

Airway Assessment <input type="checkbox"/> Normal <input type="checkbox"/> Difficult <input type="checkbox"/> Equivocal	Mouth Opening ≥ 2 Fingers <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyromental Distance ≥ 3 Fingers <input type="checkbox"/> Yes <input type="checkbox"/> No
Cricoid Palpation <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Thrust <input type="checkbox"/> Yes <input type="checkbox"/> No	Cervical Restriction <input type="checkbox"/> Yes <input type="checkbox"/> No

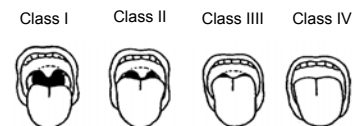
Neuro: _____
Respiratory: _____
Cardiovascular: _____
Other: _____

Dentition

Bridgework
 Crowns
 Partial Plate
 Normal
 Dentures
 Patient Informed Possible Damage to Teeth



Hypopharynx Visualization



Lab Results

BUN _____	Na _____	pH _____	Hgb _____	PT _____	Urine Prot. _____ Sugar _____ Acetone _____
Cr _____	K _____	PCO ₂ _____	HCT _____	PTT _____	
BS _____	CL _____	pO ₂ _____	Plts _____	BI.T _____	
		HCO ₂ _____	WBC _____	INR _____	

Other Lab Results: _____

EKG: N/A On Chart
Result: _____

Chest X-ray: N/A On Chart
Result: _____

To Be Checked:
 EKG Bloodwork
 Hospital Old Chart Other _____

ASA STATUS: ASA PS 1 2 3 4 5 6 E Peat Review: _____ Date: _____ Time: _____

ANESTHESIA RECORD

DATE _____ NAME OF PATIENT _____

TIME _____ am/pm NAME OF PHYSICIAN _____

1. I hereby authorize Dr. _____ and assistants of the surgeon's choice to perform upon _____ the following operations:
(state name of patient)

(state nature of procedures to be performed)

And if any unforeseen condition arises in the course of the operation calling in the surgeon's judgment for procedures in addition to or different from those now contemplated, I further request and authorize the surgeon and his/her assistants to do whatever he/she deems advisable in the course of the operation.

2. I hereby authorize Experior Surgery Center, its medical and professional staffs, employees and agents, and authorized transcription vendors to undertake the appropriate service and care necessary in conjunction with those procedures which I have authorized the above-named physician to undertake in his/her efforts to alleviate my said condition or conditions. I also consent to the disposal of any tissue or body parts which may be removed.
3. The nature and purpose of the operation, possible alternative methods of treatment, risks involved and the possibility of complications have been explained to me. I have had an opportunity to discuss this operation with the doctor or doctors concerned, and I have received answers to all questions I asked. I know my doctor may have ownership in this facility, and am aware that I may have surgery performed at any other facility where my surgeon has privileges.
4. I have been informed that in the performance of any surgical procedure there are other risks, such as severe loss of blood, infection, cardiac arrest, etc. I acknowledge that no guarantees or assurances have been made to me concerning the results of the operation or procedure. Furthermore, in the event a blood transfusion is required:
 I give consent to receive blood or blood products. I do not give consent to receive blood or blood products.
5. I acknowledge that I have, to the best of my ability, informed my surgeon, Dr. _____, of all known allergies, unusual reactions to medications, radiopaque and radioactive media and anesthetic agents.
6. I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for this service, with the exception of _____.
(state "none", spinal anesthesia, etc.)
7. I have had nothing to eat or drink (including water) since _____ on _____. Small sip of water with medications: _____.
(time) (date) (time)
8. The advantages and disadvantages of outpatient surgery have been explained to me. I realize that, following my operation, admission to a hospital might be advised.
9. Following surgery, I will have a responsible adult drive me home as per previous arrangements. I realize that impairment of full mental alertness may persist for several hours following the administration of anesthesia and I will avoid making decisions, or taking part in activities which depend upon full concentration or judgment during the period.
10. I consent to taking and publication of any photographs and/or video taping in the course of this operation for the purpose of advancing medical education, provided my identity is protected.
11. I consent to the admittance of qualified observers, such as nursing students, in the Operation Room for the purpose of medical education, provided my identity is protected.

I CERTIFY THAT I HAVE READ, OR HAVE HAD READ TO ME, AND FULLY UNDERSTAND THE ABOVE CONSENT FOR THIS OPERATION, THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED.

Patient

Witness

If the patient is not able to sign for him/herself, the following is to be completed and appropriate signature obtained.

Patient name above is a minor of _____ years of age.

Patient name above is unable to sign because _____

Witness

Signature of Closest Relative or Legal Guardian

CONSENT FOR OPERATION, ANESTHESIA OR OTHER PROCEDURES

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES

Experior Surgery Center requires the following notice be signed by each patient prior to the scheduled procedure in order to be in compliance with the Self-Determination Act (PSDA) and State law and rules regarding Advance Directives. Advance Directives are statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The Advance Directives are made and witnessed prior to serious illness and injury.

There are many types of Advance Directives but the two most common forms are:

Living Wills

These generally state the type of medical care an individual wants or does not want if he/she becomes unable to make his/her decisions.

Durable Power of Attorney for Health Care

This is a signed, dated and witnessed paper naming another person as an individual's agent or proxy to make medical decisions for that individual if he/she should become unable to make his/her own decisions.

In the ambulatory care setting, if a patient should suffer a cardiac or respiratory arrest or other life-threatening situation, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it will not honor previously signed Advance Directives for any patient. If you disagree, you must address this issue with your physician prior to signing this form.

I understand that I am not required to have an Advance Directive in order to receive medical treatment in this health care facility.

I **have** executed an Advance Directive.

I **have not** executed an Advance Directive.

I have read and fully understand the information presented in this release form.

Witness to Patient's Signature

Patient's Signature

Date: _____

Date: _____

If patient is unable to sign or is a minor, please sign below:

Witness to Relative/Guardian's Signature

Closest Relative or Legal Guardian's Signature

Date: _____

Date: _____

It would help us to know...

PLEASE CHECK ()

Date of Surgery: _____

Physician: _____

Were you treated in a courteous, pleasant and professional manner?

Yes

No

Do you feel that your Pre-Op and Post-Op instructions prior to surgery were adequate?

Yes

No

Do you feel the Experior Surgical Center personnel were interested in you as a person?

Yes

No

Were you comfortable with the lighting, temperature, and general surroundings?

Yes

No

Do you feel your separation from your family member or friend was minimal?

Yes

No

Were written instructions given to you and reviewed with you before leaving the Center?

Yes

No

How would you rate your overall experience?

EXCELLENT

GOOD

FAIR

POOR

Are there any ways that the staff (office, nursing, surgeon, anesthesiologist) could improve your experience the day of surgery?

Please list any general comments or suggestions:

Please return this form in the addressed, stamped envelope you were given at the time of discharge. Signing your name is optional.

THANK YOU IN ADVANCE FOR YOUR COOPERATION!

SURVEY

Experior Surgery Center Preference Card

Surgeon: SALLY H. COOPER
Glove Size: 7.0

Procedure:

49568 HERNIA REPAIR WITH MESH
 Position: Supine
 Prep: NPO 12 Hours
 Drapes: Regular
 Notes: Bring her cart in and use Bard Scope. Prefers classical music.
 Berlioz, Mahler, Mozart, and Bach CD's.
 Please have instruments at her left.

Supplies:

Category	Item Number	Description	Open	Quantities Standby	Duplicate	Cost
*** SURG - Surgery						
	250	DRG 367-1245				
	270	CSR 27360-100				
	270	LAB ORG 35514				
	270	ORT K 121				
	270	PRE 30165-620				
		Maalox -Plus X/S 1 OZ.	2	2	No	0.46
		Labels Pathology Warning	3	3	No	9.85
		Calcium Chloride 0.25 M	3	3	No	0.00
		Saw Balde Disp sagtil	2	2	No	35.00
		Dressing Uniflex IV 6X 8.5	1	12	No	0.45
*** ANES - Anesthesia						
	250	DRG 273 5017				
	250	DRG B&O				
	250	DRG 2341				
		Na Bicard SDV 8.4%, 50ML	12	2	No	2.28
		B&O Supp 15 A	1	1	No	2.18
		Dantium 36 Vials	1	1	No	1656.36
*** RECV - Recovery						
	270	CSR 173421				
	270	ORT 12761				
	300	LAB 56211				
		Endo Gauge 30 12mm	1	1	No	16.00
		K wire Smooth 0.054 G	2	3	No	6.50
		U/A Without Micro	1	1	No	10.00