PICK UP YOUR PRESCRIBED MEDICATIONS A FEW DAYS BEFORE SURGERY. DO NOT WAIT TILL THE LAST MINUTE!

PRE-OPERATIVE CHECKLIST

ORTHOPEDICS AND SPINE PATIENTS

- STOP taking Aspirin and other blood thinning medications at least 7-10 days before surgery
- Do not eat or drink anything after midnight or at least 8 hours prior to your scheduled surgery time
- Bathe thoroughly the night before surgery with soap and water – be sure to scrub and shave area of surgery with a clean blade.
- Bring a copy of your advance directive if you want us to have a copy in the chart
- Bring your medication list !
- You must have a dependable transport home after surgery. You will not be allowed to drive by yourself. You must have somebody drive you home.
- Arrange for a caregiver for at least 1-2 weeks after discharge home as needed.
- Be sure to get your post operative appointment card from the staff before discharge home – usually 2 weeks. Spine surgery patients are seen the next day in office by physician.
- If you take blood pressure medication <u>you will</u> take that on the morning of surgery with a SMALL sip of water. This will help control your blood pressure during surgery.
- If you are diabetic – please inform us so we can guide you on medications to take on the morning of surgery. Keep hard candy in your bag at all times.

WEST COAST SURGERY

PACKET TO INCLUDE:

PATIENT DEMOGRAPHICS

PATIENT ID COPY/ INSURANCE CARD COPY (WORKCOMP NONE)

SURGICAL AUHTORIZATION COPY

WEST COAST SURGERY

Patient Information

Patient Name: ______ DOB: ______ Sex: ______

Home Phone: ______ Cell: ______

Address: ______

INSURANCE ______ SSN: ___/___/___

E-MAIL (REQUIRED)

* DATE OF INJURY (WORK COMP ONLY):

Emergency Contact Information

WEST COAST SURGERY

Emergency Contact: ______ Relationship: ______

Home Phone: ______ Cell: ______

Emergency Contact: ______ Relationship: ______

Home Phone: ______ Cell: ______

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

______ Patient

______ Date

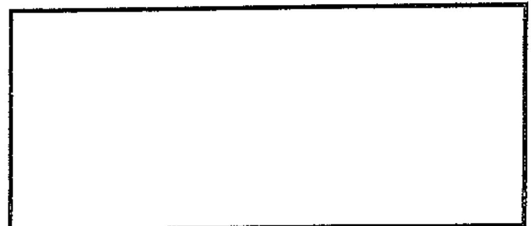
WEST COAST SURGERY INC

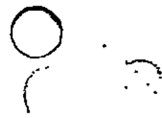
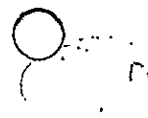
Smoking Waiver

1. I understand that smoking may be hazardous to my health and smoking while hospitalized is against medical advice.
2. I understand that if I choose to leave the patient unit that a family member or friend who is over 18 years old must accompany me.
3. I understand that I have the responsibility to inform my caregivers whenever I am leaving the patient unit and when I return.
4. I have been advised that when I leave the patient unit to smoke that I interrupt the hospital's ability to provide continuous medical care and monitoring. Should a medical emergency occur while at the designated smoking area, or while en route to/from the smoking area, I understand that hospital employees may not be able to respond as quickly to my medical needs as if I were in my patient room or treatment area.
5. I have read the WEST COAST SURGERY Non-Smoking Policy and Procedures and agree to comply with them.
6. I waive any claims that may arise from or be caused in whole or in part by my violation of the Non-Smoking Policy and Procedures.
7. I waive any claims that may arise from or be caused in whole or in part by my decision to leave the patient care area to smoke.
8. The foregoing waivers shall extend to WEST COAST SURGERY and my physician, and to their respective officers, directors, agents and employees.

Witness Signature　　　Date　　　Type or print Patient Name

Patient Signature　　　Date



WEST COAST SURGERY

PATIENT COMMUNICATION

WEST COAST SURGERY

PATIENT NAME ______________________________

FAMILY ______________ FRIEND ______________

____ WAITING ____ WILL RETURN @ __________

CALL RIDE @ ______________________________

_____ SEE DR. AFTER SURGERY

FILE: Complete / Incomplete

H/P ______________________

LABS ______________________

EKGS ______________________

CXR ______________________

REQUIRED

PREFFERED LANGUAGE FOR COMMUNICATION

____

UNDERTAKING BY PATIENT OR GUARDIAN ATTENDANT

I understand that West Coast Surgery Inc. requires a responsible adult/guardian to drive the patient home and stay with him/her 24 hours after surgery. Risks include swelling, bruising, bleeding, pain, fainting, falling, infection, death, and/or any other risks discussed by the treating physician, which could be potentially minimized or detected earlier.

I understand that if I choose not to comply, I still wish to proceed with the surgery.

Patient/Guardian signature:
Relationship:

Date:____________________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, ______________________________ have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I have received a copy of the patient Bill of Rights, and the patient responsibility form. I have received information about the policy on Advanced Directive. I have been informed that my Medical Records may be subject to outside Peer Review. I have received a copy of West Coast Surgery Inc. Grievance procedure. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

____

____

____

____

Further, I permit a copy of this authorization to be used in place of original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed:______________________________

Date:_______________________

7)

WEST COAST SURGERY

Assignment and Release

I, ______________________ have insurance with the above mentioned carrier and assign
directly to Dr. Ahmad all medical benefits. I understand that I am financially responsible for all
charges incurred and not covered by my health plan. I understand that a copy of my insurance
card (front & back) as well a photo ID is required at time of services for billing purposes. I
hereby authorized Dr. Ahmad to release all information necessary to secure payment of
benefits. I authorized the use of this signature on all my insurance submissions.

______________________ Signature

______________________ Date

HIPAA

I, ______________________, fully understand that all health information given to the Dr. and his
staff is personal and confidential. I also understand that absolutely no information will be given
to any person without prior written consent from myself and understand that it must kept on
file and updated yearly.

______________________ Signature

______________________ Date

Consent for Treatment

I hereby authorized and consent Dr. Ahmad to interpret/perform any x-ray exam, laboratory test and all
treatment rendered to myself or my children.

______________________ Signature

______________________ Date

Medical Authorization IF APPLICABLE

I request the payment of authorized Medicare benefits be made either to me or on my behalf to the
physician rendering service. Co-insurance and deductible are based upon the charges determination of
the Medicare Carrier.

______________________ Signature

______________________ Date

WEST COAST SURGERY

Patient Communication Preferences Regarding PHI

Telephone Communication Preferences:

Home Phone ______________________________

Mobile Phone ______________________________

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 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?

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

Name	Telephone
______________________________	______________________________

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 RIGHTS

The patient will be provided a copy of the "Patient Rights and Responsibilities" prior to the procedure.

* The patient has the right to be free from discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression.
* The privacy of all patients shall be respected at all times. Patients shall be treated with respect, consideration and dignity.
* Patients shall receive assistance in a prompt, courteous, and responsible manner.
* Patient disclosures and medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patients' and/or designated representatives' express written approval. Patients are given the opportunity to approve or refuse the release of their medical records.
* Patients have the right to know the identity and status of individuals providing services to them.
* Patients have the right to change providers if they so choose. Patients are informed of the credentials of all staff who will be providing care during the patient's stay.
* Patients, or a legal authorized representative, have the right to thorough, current and understandable information regarding their diagnosis, treatment options and prognosis, if known, and follow-up care. All patients will sign an informed consent form after all information has been provided and their questions answered.
* When it is medically inadvisable to give such information to the patient, the information is provided to a person designated by the patient or to a legally authorized person.
* Patients have the right to choose another facility for their procedure.
* Unless participation is medically contraindicated, patients have the right to participate in all decisions involving their healthcare.
* Patients have the right to refuse treatment and to be advised of the alternatives and consequences of their decisions. Patients are encouraged to discuss their objectives with their provider.
* Patients have the right to refuse participation in experimental treatment and procedures. Should any experimental treatment or procedure be considered, it shall be fully explained to the patient prior to commencement
* Patients have the right to make suggestions or express complaints about the care they have received and to submit such to the Center Administrator or Clinical Supervisor so the grievance may be addressed in a timely manner.
* Patients have the right to be provided with information regarding emergency and after-hours care.
* Patients have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the expense of the second opinion rests solely with the patient.
* Patients have the right to a safe and pleasant environment during their stay.
* Patients have the right to have visitors at the Center as long as visitation does not encumber Center operations and the rights of other patients are not infringed.
* Patients have the right to have procedures performed in the most painless way possible.
* Patients have the right to an interpreter if required.
* Patients have the right to be provided informed consent forms as required by the laws of the State of California.
* Patients have the right to truthful marketing and/or advertising regarding the competence and capabilities of the Center and its staff.
* Patients have the right to have copies of their "Advance Directives" and "living Wills" in their medical records and to have Center staff honor these wishes to the extent feasible. However, due to the Center's limited capabilities, in the event of an emergency, the patient will be transferred to the nearest hospital. Hospital staff will be informed of the existence of the Advance Directives and such will be provided if the Center has copies.
* Patients will be provided, upon request, all available information regarding services available at the Center, as well as information about estimated fees and options for payment.
* Patients have the right to approve the release of their medical records to other care providers, legal representatives and other persons authorized by the patient.
* Patients have the right to be informed that their provider may have a financial interest in the Center.
* Patients have the right to exercise his/her rights without being subject to discrimination or reprisal.
* Patients have the right to be free from all forms of abuse or harassment.
* 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.

ATIENT RESPONSIBILITIES

* Patients are expected to provide complete and accurate medical histories, to the best of their ability, including providing information on all current medications, over-the-counter products and dietary supplements and any allergies or sensitivities.
* Patients are responsible for keeping all scheduled pre- and post-procedure appointments and complying with treatment plans to help ensure appropriate care.
* Patients are responsible for reviewing and understanding the information provided by their Physician or nurse. Patients are responsible for understanding their insurance coverage and the procedures required for obtaining coverage.
* Patients are responsible for providing insurance information at the time of their visit and for notifying the receptionist of any changes in information regarding their insurance or medical information.
* Patients are responsible for paying all charges for co-payments, co-insurance and deductibles or for non-covered services at the time of the visit unless other arrangements have been made in advance with the Center Administrator.
* Patients are responsible for treating Physicians, Staff and other patients in a courteous and respectful manner.
* Patients are responsible for asking questions about their medical care and to seek clarification from their Physician of the services to be provided until they fully understand the care they are to receive.
* Patients are responsible for following the advice of their provider and to consider the alternatives and/or likely consequences if they refuse to comply.
* Patients are responsible for expressing their opinions, concerns or complaints in a constructive manner to the appropriate personnel at the Center.
* Patients are responsible for notifying their health care providers of patient's Advance Directives, Living Wills, Medical Power of Attorney or any other directives that could affect their care.
* Patients are responsible for having a responsible adult transport them from the Center and remain with the patient for twenty-four (24) hours, if required by the Physician.

FOR COMPLAINTS

The patient or family may voice concerns or complaints without having care affected in any way. They may discuss their concerns with their doctor, nurse, or other caregiver. If preferred, the patient/caregiver may contact the following departments. For Medi-Cal Privacy Office and Senior Staff Counsel, 1501 Capitol Avenue MS4721 PO Box 997413 Sacramento, CA 95899 and for Non Medi-Cal: Health and Human Services, Federal Building Ste. 4-100, San Francisco, CA 94103 or their Ombudsman at 800-MEDICARE or www.cms.hhs.gov/center/ombudsman.

Patient Signature ______________________________