Newport Beach

SURGERY • CENTER

PRE-PROCEDURE PACKET INSTRUCTIONS

This packet contains important information relating to your surgery or procedure. You need to fill out enclosed forms before you arrive at the Center. **Please complete, sign and bring the YELLOW forms with you the day of your surgery or procedure:**

1. Patient Identification/Site Verification Checklist
2. Patient's Home Medications
3. Pre-anesthesia Surgery Questionnaire
4. HIPAA Notice of Privacy Practices
5. Race/Ethnicity Form (required by the State of California)
6. CMS Prior to Surgery/Procedure Notification Requirements

Please read the SAMPLE consent forms included in the envelope. You will be required to sign actual consent forms when you arrive.

Bring your driver's license and your insurance card for proper identification.

We are happy to serve you and strive to provide our patients the best possible care. We hope your experience is a positive one.

Newport Beach Surgery Center Staff

BILLING INFORMATION

Common Questions About Your Financial Obligations:

Will my insurance carrier cover my procedure?

- Insurance benefits vary between health plans. We will contact your insurance provider; however this is your health insurance plan so we urge you to contact your insurance carrier to find out about your coverage so there are no surprises.

Will you bill my insurance company for my procedure?

- Yes. Newport Beach Surgery Center (NBSC) is contracted with most health plans. We will contact your insurance carrier prior to your admission to determine your benefit coverage. You must pay your deductible and/or co-insurance as conveyed by your insurance carrier upon admission, if not your procedure will be cancelled. When you register NBSC will copy your health insurance ID card as a reference for your coverage and the pending claim.

Does Newport Beach Surgery Center accept payment from Medicare?

- Yes. We will submit your procedure to Medicare. Again, you must pay the Medicare deductible and/or co-insurance upon admission, if not your procedure will be cancelled. However, if you have Medicare supplemental insurance coverage NBSC will bill your supplemental insurance carrier for your deductible and/or coinsurance.

Will you bill me for my deductible and/or coinsurance?

- No. You must pay any deductible and/or coinsurance amounts upon admission. Failure to do so will result in the cancellation of your procedure.

What types of payment methods are acceptable?

- ***The Center does not accept personal checks***. Acceptable methods of payment are: ATM Debit Card, American Express, Discover Card, MasterCard, Visa credit cards and cash or a recognized bank issued Certified Check. ***Again, personal checks are not accepted.***

Who else might I receive a bill from?

- You will be billed from each physician who takes part in your procedure. These physicians are your Surgeon or Gastroenterologist, Anesthesiologist if used for your procedure, and Pathologist if used for your procedure. You will also be billed when any outside laboratory and/or X-Ray services are used.

I do not have insurance. May I make payments?

- No. NBSC will not accept a payment plan. Payment is due upon admission.

Who can I call if I have questions about my financial obligations?

- Insurance and Pre-Registration Representative
  (949) 631-0988 ext. 3044 or ext. 3031

Newport Beach

SURGERY CENTER

OUR MISSION and VALUE STATEMENT

MISSION STATEMENT

To provide our patients personalized care of the highest quality by healthcare professionals who do their best to satisfy their patients' needs.

Value Statement

At Newport Beach Surgery Center our primary charge is to our patients and their families. We, the staff, are committed to our profession and to each other to make certain that our performance exceeds our patient's expectations each and every day.

As a physician owned healthcare facility, our ability to bring new techniques, technology, and after care services is not impaired by a Corporations' culture or a large organizations' bureaucracy. Decisions are made here in the community in which we live and provide services.

As physician owners, we most of all understand that the staff of Newport Beach Surgery Center is what makes the Center what it is. The staffs' performance is what our patients will evaluate and remember. Therefore, our expectations of our staff are extremely high which results in having healthcare professionals who also set high standards for themselves and their coworkers.

Newport Beach
SURGERY • CENTER

361 Hospital Road, Suite 124 • Newport Beach, CA 92663 • (949) 631-0988

DISCHARGE INSTRUCTIONS

Medication given may have significant effects after discharge; therefore, on the day of surgery:

1. You must be accompanied by a responsible adult upon discharge and for 24 hours after surgery.
2. Do not drive a motor vehicle, operate machinery, power tools or appliances, drink alcoholic beverages, or make critical decisions for 24 hours.
3. Be aware of dizziness which may cause a fall. Change positions slowly.
4. Diet, activity, and bathing instructions per your surgeon.
5. Pain: There may be some pain associated with certain procedures. Your surgeon may have given you a prescription for medication. If this medication does not provide adequate relief, call your surgeon.
6. Nausea/Vomiting: Nausea and vomiting may occur as you become more active or begin to increase food intake. If this should happen, decrease activities and return to liquid. If the problem persists, call your surgeon.
7. Urinating: Notify your surgeon if you have not urinated within 12 hours after discharge.
8. Do not remove dressing until instructed to by your physician.
9. Keep dressing dry and clean.
10. Elevate operative extremity above heart level.
11. Ankle pump and deep breathing exercises while resting.
12. _____
13. Call your surgeon if: Surgeon Phone Number _____
    a. You have any questions.
    b. Temperature is 101 degrees or above.
    c. Increased bleeding, swelling, or pain.
    d. Signs of infection ñ redness, foul odor, or purulent drainage.
    e. Operative extremity becomes cold, blue, tingly, or numb.
14. Call doctor _____ for an appointment in _____ day(s)/week(s).
15. ❑ Refer to Doctor's post-op instruction sheet

_____
_____
_____
_____
_____
_____

If unable to contact your surgeon, call the nearest hospital emergency room for advice or assistance.

I have received, read, and understand the above instructions. All of my questions have been answered to my satisfaction.

Nurse _____

Date _____ Time _____

Patient/Caregiver _____

NEWPORT BEACH SURGERY CENTER

DATE	TIME IN	LAST NAME	FIRST NAME	M.I.	PAYMENT	C.I.

M/F	DOB	AGE	MSW	HOME PHONE	EMERGENCY CONTACT	PHONE

DO NOT COMPLETE

ADDRESS				ZIP

PRIOR ADMIT	SSN	DRIVER LICENSE	OCCUPATION	WORK PHONE

ORIGINAL CONSENTS TO BE SIGNED UPON ADMISSION

RESPONSIBLE PARTY IF OTHER THAN ABOVE			

RELATION TO RESPONSIBLE PARTY	RESPONSIBLE PARTY SSN	RESPONSIBLE PARTY EMPLOYER	RESPONSIBLE PARTY PHONE

PRIMARY INS. CO. NAME/NAME OF INSURED			SECONDARY INS. CO. NAME/NAME OF INSURED		

I.D. #/SSN	GROUP #	AUTHORIZATION	I.D. #/SSN	GROUP #	AUTHORIZATION

INSURED'S EMPLOYER AND PHONE	INSURED'S EMPLOYER AND PHONE

SURGEON	DOI	CLAIM #	ATTENTION

DIAGNOSIS

PROPOSED SURGERY (LINE 1)

PROPOSED SURGERY (LINE 2)

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD(S)

I understand that fees quoted are estimated and that actual charges cannot be determined until after surgery.

I hereby assign to and authorize payment directly to the facility named above (the"facility") of all benefits due me under Medicare, Medicaid, or any insurance policy providing benefits for facility charges, for services rendered by the facility.

A photostatic copy of this agreement shall be considered effective and valid as the original.

I irrevocably agree that the facility may disclose, to the extent allowed by law, my medical and financial record to (a) any affiliate of the facility, specifically including Newport Beach Surgery Center and its employees and agents, including entities under contract with same to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to the facility or to me, or any person or entity responsible for all or part of the facilities charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred by the facility or by my physician for continued care; (d) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Health Care Financing Administration, any governmental or accrediting agency, or their agents or employees.

All facility charges are due and owing upon admission in consideration of the services to be rendered, to the extent not expressly prohibited by law or by the contract between the facility and my third party payer. I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law. I understand that I am financially responsible for charges not paid within said 60 days and for charges not covered by this assignment. I understand that the facility files for reimbursement from my insurer or other payor as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the facility.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due.

Facility employees are NOT able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

PATIENT **DATE** **GUARANTOR** **DATE**

WITNESS **DATE**

NEWPORT BEACH SURGERY CENTER 361 Hospital Road, Suite 124 • Newport Beach, CA 92653 • (949) 631-0988

PATIENT NAME	ACCOUNT RECORD	DATE
PROCEDURE (LINE 1)		
PROCEDURE (LINE 2)		
REFERRING PHYSICIAN	DATE OF BIRTH / AGE / SEX / ASSIGNED	

DO NOT COMPLETE

ORIGINAL CONSENTS TO BE SIGNED UPON ADMISSION

INFORMED CONSENT TO OPERATION AND OTHER MEDICAL SERVICES INCLUDING TRANSFUSION(S)

1. The facility maintains personnel and facilities to assist physicians and surgeons as they perform various surgical operations and other diagnostic or therapeutic procedures. Generally, such physicians, surgeons and practitioners are not agents, servants or employees of the facility, but independent contractors and, therefore, are the patient's agents or servants. The facility provides nursing and support services and facilities; the facility does not provide medical physician care.
2. The procedure(s) listed to be performed and the advantages and disadvantages, risks and possible complications, as well as the alternatives have been explained to me by my physician. The doctor has satisfactorily answered my questions.
3. My consent is given with the understanding that any operation or procedure involves risks and hazards. The more common risks include; infection, bleeding with the need for blood transfusion, nerve injury, blood clots, heart attack, stroke, allergic reactions, damage to teeth or bridgework, and pneumonia. These risks can be serious and possibly fatal.
4. I authorize and direct the above-named surgeon to arrange for such additional services for me, as he or she may deem necessary or advisable, including, but not limited to, the administration and maintenance of anesthesia, and the performance of pathology and radiology services, to which I hereby consent. I accept financial responsibility for any additional services deemed necessary by my physician.
5. I authorize the pathologist or physician to use his or her discretion in disposing of any member, organ, implant, prosthetic, or other tissue removed from my person during the operation(s) or procedure(s).
6. The facility may participate in residency and other training programs for physicians, allied health professionals, and other providers of services. All care rendered by individuals in training will be supervised and reviewed, as appropriate, by appropriate personnel. I hereby consent to care and treatment from individuals in training and the review of my patient record by same.
7. In the event of a medical emergency, **I DO / DO NOT** (*circle* one) authorize the administration of transfusions of whole blood or blood products to me as may be deemed advisable by the anesthesiologist, my attending physician, and/or his associates or assistants. I understand that despite the exercise of due care, the transfusion of blood or blood products is always attended with the possibility of some ill effects such as the transmission of hepatitis, HIV, or certain other diseases, accidental immunization, or allergic reaction. I understand that in an emergency it may be necessary for the patient's well-being to use existing stocks of blood which may not include the most compatible blood types. (*If the patient circles* **DO NOT**, *obtain the patient/guardian signature on the Refusal to Permit Blood Transfusion section.*)
8. In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor or employee of the facility, I consent to testing for HIV and hepatitis.
9. I understand that it is my responsibility and I have arranged for a responsible adult to drive me home and remain with me following my surgery/procedure(s). I acknowledge that I have been advised by facility personnel not to drive until the effects of any medications have worn off. I understand this to mean that I should not drive until the day after my surgery/procedure(s) or as directed by my physician.
10. I hereby consent to the presence of other person(s) for the sole purpose of observation and/or education. I understand that this individual(s) will not participate in the actual procedure(s).
11. I consent to the use of video-taping or photography that may be used for scientific or teaching purposes, and to the review of my medical record for bona fide medical healthcare research, providing my name or identity is not revealed.
12. I release the facility from any responsibility for loss and/or damage to money, jewelry, or other valuables I brought into the facility.
13. I understand that if I am pregnant, or if there is any possibility I may be pregnant, I must inform the facility immediately since the scheduled procedure(s) could cause harm to my child or myself.
14. I am aware that my physician may have an ownership interest in the facility, and I acknowledge that I have a right to have the procedure(s) performed elsewhere.
15. I understand that in the rare event that hospitalization is required during or immediately after surgery, my physician will arrange for my transfer to a local hospital.
16. I have not eaten or taken fluids, not even water, since DATE _____TIME_____AM / PM, except for a sip of water taken with medication as instructed by my physician.
17. My signature below constitutes my acknowledgement that: (1) I have read or have had read to me the foregoing, and agree to it; (2) the procedure(s) has been adequately explained by my physician; (3) I authorize and consent to the performance of the procedure(s) and any additional procedure(s) deemed advisable by my physician in his or her professional judgment; (4) I authorize and consent to the administration of anesthesia for the said procedure(s).
18. If I am not the patient, I represent that I have the authority of the patient, who, because of age or other legal disability, is unable to consent to the matters above, (a) I have full right to consent to the matters above, and I consent to same, (b) I hereby indemnify and hold harmless the facility, its employees, agents, medical staff, partners and affiliates from any cost of liability arising out of my lack of adequate authority to give this consent.

DATE _____ **TIME**_____ **PATIENT'S SIGNATURE** _____

DATE _____ **TIME** _____ **WITNESS TO SIGNATURE** _____

If patient is a minor or unable to sign, complete the following:

❑ Patient is a minor ❑ Patient is unable to sign because: _____

DATE _____ **TIME** _____ **SIGNATURE** _____

RELATIONSHIP _____

DATE _____ **TIME** _____ **WITNESS TO SIGNATURE** _____

NEWPORT BEACH SURGERY CENTER 361 Hospital Road, Suite 124 • Newport Beach, CA 92653 • (949) 631-0988

PATIENT NAME	ACCOUNT RECORD	DATE
PROCEDURE (LINE 1)		
PROCEDURE (LINE 2)		
REFERRING PHYSICIAN		

DO NOT COMPLETE

ORIGINAL CONSENTS TO BE SIGNED UPON ADMISSION

REQUEST FOR ADMINISTRATION OF ANESTHESIA

I Understand that it will be necessary to be placed under anesthesia in order to perform the above-described operation, and I consent to the use of anesthesia as deemed necessary and appropriate by my anesthesiologist, surgeon and nurse anesthetist. Anesthesia involves risk in addition to the risks of the surgical procedure itself. These risks include, but are not limited to, adverse drug reactions brain damage, death, nerve injury, damage to teeth or dental work, damage to vocal cords, respiratory problems, minor pain and discomfort, damage to arteries or veins, headaches, backache, or worsening pre-existing disease(s). The purpose, necessity, and risk of anesthesia have been explained to my satisfaction by a physician and there has been sufficient opportunity to discuss the proposed treatment and associated risks

I DECLARE AND REPRESENT THAT I HAVE READ THE ABOVE AND UNDERSTAND IT IS TRUE. No guaranty or warranty has been made to the result of the anesthetic procedures.

DATE _____ **TIME** _____ **PATIENT/AUTHORIZED AUTHORITY** _____

DATE _____ **TIME** _____ **WITNESS TO SIGNATURE** _____

ADVANCED DIRECTIVES/LIVING WILL/HEALTH CARE PROXY

Under federal and state law, you or your representative have the legal right to make informed decisions regarding your care. It is our policy, regardless of the contents of any advanced directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at Newport Beach Surgery Center we will initiate resuscitation 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 directive or health care power of attorney.

I understand I have the right to make choices regarding life-sustaining treatment (including resuscitative measures).

- ❑ Yes, I have provided the facility with a copy of my Advanced Directive/Living Will/Health Care Proxy. The facility has explained to me their policy regarding the honoring of this document and I agree to proceed with the proposed procedure as scheduled.
- ❑ Yes, I have executed an Advanced Directive; however, I have not provided one to the facility.
- ❑ No, I have not executed an Advanced Directive.
- ❑ I wish to have information on how I can obtain an Advanced Directive. Information received _____(Initial).

DATE _____ **TIME** _____ **PATIENT/AUTHORIZED AUTHORITY** _____

REFUSAL TO PERMIT BLOOD TRANSFUSION

Date:_____ Hour _____ A.M. P.M.

I request that no blood or blood derivatives be administered to _____ during this hospitalization, notwithstanding that such treatment may be deemed necessary in the opinion of the attending physician or his/her assistants to preserve life, or promote recovery. I hereby release the hospital, its personnel, and the attending physician from any responsibility whatsoever for unfavorable reactions or any unforward results due to my refusal to permit the use of blood or its derivatives, and I fully understand the possible consequences of such refusal on my part.

When a patient is a minor or incompetent to give consent:

_____ (Signature of Patient)

_____ (Signature of Patient's Husband or Wife)

_____ (Signature of person authorized to consent for Patient)

_____ (Relationship to Patient)

_____ (Witness)

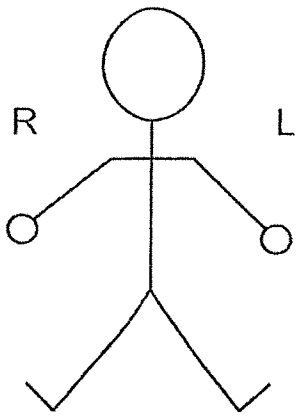
Newport Beach

SURGERY • CENTER

Patient Identification/Site Verification Checklist

PATIENT TO COMPLETE:

Indicate surgery site with an arrow on the stick figure



Patient Name:_____

Date of Birth:_____

Procedure:_____

_____

_____

Patient Signature:_____

↓ PATIENTS DO NOT WRITE BELOW THIS LINE ↓

Receptionist to Complete:

(check box) (initials)

- ☐ Patient Identified by name and date of birth _____
- ☐ Procedure confirmed with patient _____

Pre-op Nurse to Complete:

- ☐ Patient verbalizes name and date of birth _____
- ☐ Procedure, site/side confirmed per P&P _____
- ☐ H&P reflects correct patient, procedure and site _____
- ☐ Imaging studies, if applicable, confirm operative site _____

Intra-op Nurse To Complete:

- ☐ Patient verbalizes name and date of birth _____
- ☐ Procedure, site confirmed per P&P _____
- ☐ H&P reflects correct patient, procedure and site _____
- ☐ Diagnostic studies, if applicable, confirm operative site _____
- ☐ VTE risk assessment completed and on medical record _____
- ☐ Time Out observed time _____

Patient sticker

SIDE 1

Newport Beach
SURGERY • CENTER

CURRENT MEDICATIONS

LIST ALL ALLERGIES AND REACTIONS:

PRESCRIPTION MEDICATION LIST

NAME OF MEDICATION	DOSE	HOW OFTEN?
REASON:		
PRESCRIBED BY:	LAST TAKEN WHEN?	
NAME OF MEDICATION	DOSE	HOW OFTEN?
REASON:		
PRESCRIBED BY:	LAST TAKEN WHEN?	
NAME OF MEDICATION	DOSE	HOW OFTEN?
REASON:		
PRESCRIBED BY:	LAST TAKEN WHEN?	
NAME OF MEDICATION	DOSE	HOW OFTEN?
REASON:		
PRESCRIBED BY:	LAST TAKEN WHEN?	

(see other side to list additional medications)

NON-PRESCRIPTION MEDICATION VITAMIN AND HERB LIST

NAME OF MEDICATION	DOSE	HOW OFTEN	LAST DOSE DATE/TIME

(see other side to list additional medications)

PATIENTSIGNATURE: _____

MEDICATION LIST COMPLETED BY:

☐ **PATIENT** ☐ **OTHER (list)** _____

(PATIENT STICKER)

Reviewed by:

Pre-op RN OR/GI RN Post-op RN Other

SIDE 2

Newport Beach

SURGERY ▪ CENTER

(additional medications continued from SIDE 1)

PRESCRIPTION MEDICATION LIST

NAME OF MEDICATION	DOSE	HOW OFTEN?
REASON:		
PRESCRIBED BY:	LAST TAKEN WHEN?	
NAME OF MEDICATION	DOSE	HOW OFTEN?
REASON:		
PRESCRIBED BY:	LAST TAKEN WHEN?	
NAME OF MEDICATION	DOSE	HOW OFTEN?
REASON:		
PRESCRIBED BY:	LAST TAKEN WHEN?	
NAME OF MEDICATION	DOSE	HOW OFTEN?
REASON:		
PRESCRIBED BY:	LAST TAKEN WHEN?	
NAME OF MEDICATION	DOSE	HOW OFTEN?
REASON:		
PRESCRIBED BY:	LAST TAKEN WHEN?	

NON-PRESCRIPTION MEDICATION VITAMIN AND HERB LIST

NAME OF MEDICATION DOSE DOSE		HOW OFTEN	LAST DOSE DATE/TIME

Newport Beach SURGERY • CENTER

361 Hospital Road, Suite 124 • Newport Beach, CA 92663 • (949) 631-0988

PRE-ANESTHESIA SURGERY QUESTIONNAIRE

	YES	NO
1. Name of your regular family doctor _____ Phone _____ OR ❑ I do not have a regular family doctor		
2. Have you ever had any problems with blood pressure, previous heart disease, palpitations or angina? _____		
If yes, please explain: _____		
3. Have you had an EKG in the past? If yes, where? when _____		
4. Have you had any (Circle) breathing problems, asthma, hay fever, chronic bronchitis, emphysema or shortness of breath? _____		
5. Have you had any (Circle) seizures, convulsions, migraine headaches, fainting spells or stroke? _____		
6. Have you had (Circle) jaundice, hepatitis, liver disease or blood transfusion reactions? _____		
7. Do you have (Circle) diabetes, hypoglycemia or thyroid problems? _____		
8. Do you have kidney problems? _____		
9. Have you had (Circle) a cold, sore throat, or flu in the last two weeks? _____		
10. Any recent exposure to tuberculosis? ❑ Yes ❑ No Any of the following symptoms: night sweats, cough with bloody sputum? _____		
11. Within the last two weeks have you had any exposure to chicken pox, mumps, measles (rubeola), German measles (rubella)? _____		
12. Do you have any (Circle) physical disabilities, back pain, arthritis or bursitis? _____		
13. Do you have sleep apnea? C-PAP? Sleeping disorders? Snoring? _____		
14. Any other medical conditions? List: _____		
15. Do you have any implants? (Cardiac, Cosmetic, Orthopedic) List: _____		
16. Have you ever had motion sickness? _____		
17. Do you smoke? _____ How much/day? _____		
18. Do you drink alcoholic beverages? _____ How much/week? _____		
19. Do you use recreational drugs? _____ Please list _____		
20. Do you have (Circle) any loose teeth, dentures, permanent or removable bridges or front capped teeth? _____		
21. Do you wear contacts? _____		
22. Do you have any difficulty opening your mouth? _____		
23. Have you or any blood relative had an unusual reaction to anesthesia or malignant hyperthermia? _____		
24. Are you **allergic** to anything? List: _____		
25. Do you have a latex allergy? _____		
26. Within the last year have you had cortisone or steroids? _____		
27. Within the last two weeks have you taken (Circle) a tranquilizer, diet pills or herbal medications? _____		
28. Have you taken any medication today? List: _____		
29. Do you use aspirin, ibuprophen (Motrin), Advil, Aleve, Naproxen or Anaprox? _____		
Others _____ Last date taken? _____		
30. Do you use blood thinners (Heparin, Lovenox, Coumadin, etc.)? _____ Last date taken? _____		
31. Do you have bleeding tendencies? _____		
32. Could you be pregnant at this time? _____ Date of last menstrual period: _____		
33. Circle pain medications you have ever taken: ❑ Tylenol ❑ Percocet ❑ Codeine ❑ Aspirin ❑ Darvocet ❑ Vicodin ❑ Other _____		

34. **Height:** _____ **Weight:** _____

Previous Operations	Year Done	Type of Anesthesia (General, Epidural, Spinal, Local)	Complications (i.e. fever, nausea, vomiting, low blood pressure)

COMPLETED BY: _____

RELATIONSHIP: _____ DATE: _____

REVIEWED BY: PRE-OP RN: _____ OR/GI R.N.: _____

Newport Beach

SURGERY • CENTER

CMS PRIOR TO SURGERY/PROCEDURE NOTIFICATION REQUIREMENTS!

Advanced Directive:

Under federal and state law, you or your representative have the legal right to make informed decisions regarding your care. It is our policy, regardless of the contents of any advanced directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at Newport Beach Surgery Center we will initiate resuscitation 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 directive or health care power of attorney.

Exercise of rights and respect for property, person, privacy and safety.
You have the right to:

- Exercise your rights without being subjected to discrimination or reprisal.
- Voice grievances regarding treatment of care that is (or fails to be) furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Have a legal representative exercise your rights to the extent allowed by state law whether adjudged competent or incompetent.
- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse and harassment.

It is the responsibility of Newport Beach Surgery Center to disclose that physicians have financial interest in the Center where you have been scheduled to have your procedures/surgery as stated in the Federal Register 42 CFR 416.50 Conditions for Coverage.

To obtain a list go to http://www.newportbeachsurgerycenter.com/physicianOwners.php or contact the Center directly at (949) 631-0988.

Please Place a Checkmark in Each Box Below:

☐ I or my representative has been provided with information concerning the NBSC policies on advanced directives including applicable State health and safety information.

☐ I or my representative has been provided with verbal and written notice of the patient's rights in a language and manner that the patient or the patient's representative understands prior to the date of surgery.

☐ Physician financial interests or ownership in the ASC have been disclosed to me or my representative.

Patient/Guardian: _____

Date: _____

Witness: _____

Date: _____

PATIENT STICKER

YOUR RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION

You have the following rights regarding the identifiable health information that we maintain about you:

Confidential Communication You have the right to request a restriction in our use or disclosure of your identifiable health information for treatment, payment, or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your case or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Inspection and Copies You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. Our practices may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Reviews will be conducted by another licensed health care professional chosen by us.

Amendment You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the practice; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures All of our patients have the right to request an "accounting of disclosure." An "accounting of disclosure" is a list of certain disclosures our practice has made of your identifiable health information. All requests for an "accounting of disclosure" must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within a 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice You are entitled to receive a paper copy of our notice of privacy practices.

Right to File a Complaint If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Right to Provide an Authorization for Other Uses and Disclosures Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization. Please note, we are required to retain records of your care.

If you have any questions, requests or complaints regarding this notice of our health information privacy policies, please contact:

Newport Beach Surgery Center
361 Hospital Rd., Ste. 124
Newport Beach, CA 92663
Attn: HIPAA Officer
This notice is effective as of April 14, 2003

We are required by law to maintain the privacy of individuals and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with the HIPAA Officer in person or by phone at (949) 631-0988.

By signing this form, you consent to our use and disclosure of protected information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosure in reliance on your prior consent.

Print Name:_____ Signature:_____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Newport Beach Surgery Center
361 Hospital Rd., Suite 124
Newport Beach, CA 92663
(949) 631-0988

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Our practice is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

Treatment Our practice may use your identifiable health information to treat you. For example, we may ask you to undergo laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your identifiable health information in order to write a prescription for you, or we might disclose your identifiable health information to a pharmacy when we call and order a prescription for you. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your spouse, children, or parents.

Payment Our practice may use and disclose your identifiable health information, as needed, in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your identifiable health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your identifiable health information to bill you directly for services and items.

Heath Care Operations Our practice may use and disclose your identifiable health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your health information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice. We may use your PHI, as necessary, to contact you to remind you of an appointment.

We may use or disclose your PHI in situations without your authorization. These situations include: as required by law; public health issues as required by law; communicable diseases; health oversight; abuse or neglect, Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors, and organ donation; research; criminal activity; military activity and national security; Workers Compensation; inmates; required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of House and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent and with authorization of opportunity to object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

RACE/ETHNICITY/LANGUAGE FORM

Health facilities are required by law to provide the Office of Statewide Health Planning and Development (OSHPD) with information regarding the race and ethnicity of their patient population. If you have any questions call or write to the agency below:

MIRCal Hotline

Telephone: (916) 326-3920
Fax: (916) 327-1262
Email: MIRCal@oshpd.ca.gov

MIRCal
Patient Data Section
Healthcare Information Division
Office of Statewide Health Planning and Development
400 R Street, Suite 270
Sacramento, CA 95811-6213

***RACE* (Select One)**

_____R1 AMERICAN INDIAN OR ALASKA NATIVE

_____R2 ASIAN

_____R3 BLACK OR AFRICAN AMERICAN

_____R4 HAWIIAN OR PACIFIC ISLANDER

_____R5 WHITE

_____R9 OTHER RACE

_____99 UNKNOWN

***ETHNICITY* (Select One)**

_____E1 HISPANIC OR LATINO

_____E2 NON-HISPANIC OR NON-LATINO

_____99 UNKNOWN

***PRINCIPAL LANGUAGE SPOKEN* (Select One)**

_____ENG English

_____ARA Arabic

_____ARM Armenian

_____CHI Chinese

_____FRE French

_____CPF French Creole

_____GER German

_____GRE Greek

_____GUJ Guarathi

_____HEB Hebrew

_____HIN Hindi

_____HUN Hungarian

_____ITA Italian

_____JPN Japanese

_____KOR Korean

_____LAO Laotian

_____HMN Miao, Hmong

_____KHM Mon-Khmer, Cambodian

_____NAV Navajo

_____PER Persian

_____POL Polish

_____POR Portuguese

_____RUS Russian

_____SCR Serbo-Croatian

_____SPA Spanish

_____TGL Tagalog

_____THA Thai

_____URD Urdu

_____VIE Vietnamese

_____YID Yiddish

_____999 Unknown

OTHER _____