OUTPATIENT SURGICAL CARE, LTD.

High Quality Eye Care in a Professional and Friendly Environment

8520 E. Shea Blvd Suite 111 · Scottsdale, AZ 85260
(602) 995-3395 Fax (602) 995-1853

PATIENT PRE-REGISTRATION INFORMATION AND INSTRUCTIONS

** IMPORTANT **

PLEASE BRING THIS COMPLETED PACKET WITH YOU ON THE DAY OF SURGERY

PLEASE BRING THE FOLLOWING WITH YOU:

- Insurance cards
- Picture ID
- Current Medication List
- Responsible driver over the age of 18
- Copy of living will and/or Power of Attorney if you have one.

Welcome! You have been scheduled to have your surgery at Outpatient Surgical Care (OPSC). Thank you for choosing our facility. We know you have a choice when it comes to your healthcare, and we are grateful you chose OPSC. We know surgery can be a frightening experience and we are here to put you at ease. Please feel free to ask any questions along the way and we will be sure to have them answered in a manner by which you are comfortable.

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Dear Patient,

1. Please do not eat after the time you have been instructed, usually 6 hours prior to your scheduled surgery time and you may drink clear liquids up to 2 hours prior to your scheduled surgery.

2. **Leave your dentures and hearing aids in place**. You will be asked to remove any hearing aid on the operative side. Bring denture and/or hearing aids case.

3. Bring a photo ID and insurance cards.

4. Be prepared to pay your deductible, co-payment, lens fee, and laser fee if applicable.

   - We accept cash, personal or cashiers' checks, money orders, Visa, MasterCard, Discover, and American Express. **We do NOT accept Care Credit.**

5. Bring a copy of your Living Will and or Medical Power of Attorney, if you have one.
   - Information available at www.azag.gov

6. Leave all valuables and jewelry at home.

7. Wear loose fitting and comfortable clothing. Short sleeve shirt with a loose neckline is preferred.

8. Shower the night before or morning of surgery. Avoid using face or eye makeup, moisturizers, and perfume the day of surgery.

9. You will be receiving a call from our facility regarding your upcoming visit, medical history, and current medications.

10. Arrange for transportation. A responsible adult will need to drive you home. **Be prepared to wait approximately 2 hours**. You should plan to have a responsible adult remain with you for several hours after you are discharged.

* IT IS NOT NECESSARY TO BRING YOUR DROPS WITH YOU *

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Patient Acknowledgement Form

The following physicians have ownership in Outpatient Surgical Care: Gabriel Perry, D.O., Jay Schwartz, D.O., and Raymond Zimmerman, M.D.

Outpatient Surgical Care has provided you with a copy of the "**Statement of Patient Rights and Responsibilities**", a copy of these rights can be found posted in the facilities waiting rooms.

The **Privacy Notice** is being provided to you as a federal law requirement, HIPAA or the Health Insurance and Portability and Accountability Act. The **Privacy Notice** describes how we may use and disclose your protected health information to carry out treatment, payment, or health operations and for the other purposes permitted by law.

Outpatient Surgical Care is required by applicable Arizona State Regulations to make you aware of your right to be involved in decisions regarding your medical care at the time of service. Specifically, you have the right to execute an Advance Directive for Health Care Decision (Advance Directive) either in the form of a Living Will or a Durable Power of Attorney for Health Care. If you are interested in completing an Advance Directive the Arizona state forms are available at http://www.azsos.gov/adv_dir/., or a copy of the forms can be provided to you at the surgery center.

☐ I have not executed an Advance Directive

☐ I have executed an Advanced Directive and ***I have provided*** a copy to Outpatient Surgical Care

☐ I have executed an Advanced Directive and ***I have not provided*** a copy to Outpatient Surgical Care

The policy at OSC is to acknowledge the Advanced Directives of the patients that are presented to us. The surgical procedures performed at OSC are not considered high risk procedures and do not anticipate any untoward problems to occur. However, if an untoward event occurs to a patient while at OSC, it is the policy to stabilize and transport the patient to a nearby hospital along with a copy of their Advance Directive. Patients who decline to be stabilized and transported to a hospital will be offered care at another facility that will comply with their wishes.

☐ *I understand Outpatient Surgical Care's policy on Advance Directives and* ***agree to comply with their policy.***

☐ *I do not wish to comply with the facilities policy and wish to be rescheduled at a facility that will honor my Advance Directives.*

Patient or Patient's Representative's Signature ____________________ Date________________
OSC Representative ____ Date________________

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PLEASE READ CAREFULLY AND SIGN AT THE BOTTOM OF THE PAGE.

PATIENT FINANCIAL RESPONSIBILITY

The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (family member, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below and/or by receiving medical services from Outpatient Surgical Care, LTD, you agree:

- Outpatient Surgical Care, LTD collects the charge for the upgraded lens when selected. Your doctor will collect his/her share for the implantation of the special lens at his/her office. These costs are unrelated.
- Three offices will charge your medical insurance: Surgeon's office, Surgery Center, and Anesthesiologist.
- Once your insurance has been billed, there may be a balance for one or all of the offices and/or facilities mentioned above. Everyone will bill you separately.
- ***You are responsible for knowing your insurance policy and financially responsible for your health insurance copay, coinsurance, deductible, non-covered service, or any other patient responsibility indicated by your insurance carrier, which are not otherwise covered by supplemental insurance.***
- In the event that your health plan determines a service to be "not payable", you will be responsible for the complete charge and agree to pay the costs of all services provided.
- If you are uninsured, you agree to pay for the medical services rendered to you at the time of service.
- You authorize Outpatient Surgical Care, LTD, associated physicians and staff, to release patient information acquired in the course of examination, treatment, and surgery/procedure including but not limited to any and all medical records, notes, test results, x-ray/MRI reports, or other documents related to your treatment (including itemization of any charges and payments) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, or health care entities as they require to participate in your care.
- You authorize direct payment of medical benefits to Outpatient Surgical Care, LTD on your behalf for any services furnished to you by the facility/providers.
- You will notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim.
- Outpatient Surgical Care, LTD does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

_______________________________________ _______________
Signature of Patient, Authorized Representative or Responsible Party | Date

_______________________________________ _______________
Print Name of Patient, Authorized Representative or Responsible Party | Patient Date of Birth

_______________________________________ _______________
OSC Representative | Date

STATEMENT OF PATIENT RIGHTS
Outpatient Surgical Care, Ltd.

Your health and well-being depend on a collaborative relationship between you and your physician. In our facility, your dignity and rights as a patient will be respected regardless of your gender, sexual orientation, religion, economic status, source of payment, and cultural/national origin.

Specifically, our patients have the Right to:

- Be treated with consideration, respect, dignity, and individuality, including privacy in treatment and care for personal needs by competent personnel
- To receive assistance from family or representative to understand these rights
- To be informed of the proposed surgical procedures and the risks involved
- Prompt and reasonable response to questions or concerns
- Know the name, function, and qualifications of those providing clinical services
- Refuse care and treatment and understand probable risks or consequences of refusal
- Consent or decline participation in clinical research or experimentation
- To change providers if other qualified providers are available
- Have an Advance Directive or designate a surrogate decision maker and have such Advance Directive included in the clinical record
- Review clinical records and information pertaining to care and treatment, and have the information explained in a way that is understandable
- To have medical and financial records kept in confidence. The release of these records shall be by written consent of the patient or patient representative except as permitted by law.
- Know about business or financial relationships that could influence recommendations for care or treatment
- Express grievances without reprisal and know the process to express a grievance
- A readily available language interpreter
- Receive care in an environment free from all forms of abuse, harassment, and exploitation

COMPLAINTS

Please contact us if you have a question or concern about your rights or responsibilities. You can ask any of our staff to help you contact the Director of Nursing at the surgery center. Or you can call: 602-995-3395. We want to provide you with excellent service, including answering your questions and responding to your concerns.

Grievances may be filed with the following agencies:
Arizona Department of Health Services
150 N. 18th Ave.
Phoenix, AZ 85007
602-364-3030 www.azdhs.gov

Accreditation Association for Ambulatory Health Care (AAAHC)
5250 Old Orchard Rd #200
Skokie, IL 60077
847-853-6060 www.aaahc.org

Office of Medicare Ombudsman at 1-800-MEDICARE (1-800-633-4227) or online at
www.medicare.gov.claims-and-appeals/medicare-rights/get-help/ombudsmamn.html

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NOTICE OF PRIVACY PRACTICES
Outpatient Surgical Care, Ltd.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

The Health Insurance Portability Act (HIPAA) is a federal law which maintains that patients' health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How we may use & disclose your patient health information:

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, a nurse or medical assistant obtaining medical information about you and recording it in your medical record to determine the appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment.
Payment: We will use and disclose health information for payment purposes. For example, for obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. Example: sending a bill for your visit to your insurance company for payment.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging of legal services and to assess the care and outcomes of your case and others like it.

Special uses and disclosures:
...We will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-operative care.
...We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voicemail, or through other methods.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request:
...The right to request restrictions on certain uses and disclosures of your health information to family members, relative, close personal friends, or any other person identified by you. We are, however, not required to agree to such a restriction. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
...The right to request restrictions on certain uses and disclosures.
...In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies of your health information.
...The right to amend your protected information.
...The right to receive an accounting of disclosures of your protected health information.
...The right to obtain a paper copy of this notice form in unabridged text upon request.
...The right to file a written complaint regarding the handling of your health information.

Complaints:
If you are concerned about violations to your privacy rights, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request.
Contact Person
If you have any questions, requests, complaints, please contact:

Director of Nursing
8520 E. Shea Blvd, Suite 111
Scottsdale, AZ 85260
602-995-3395

OUTPATIENT SURGICAL CARE, LTD
PATIENT HEALTH HISTORY

**** PLEASE BRING THIS COMPLETED FORM WITH YOU ON THE DAY OF YOUR SURGERY ****

Name: ______________________________ DOB: ___________ Age: _____ Height: _______ Weight: _______
Name of the person taking you home: ________________________________ Relationship: ________________
Contact number for driver: ____

Please check all that apply, Past or Present:

Heart/Vascular:
__ Heart Attack(s), Date: __________
__ Angina/chest pain
__ Irregular heartbeat/murmur
__ High Blood Pressure
__ Heart Failure
__ Pacemaker **(Call Surgery Center for instructions)**
__ High Cholesterol
__ Other: ________________

Lungs:
__ Asthma/Wheezing
__ Emphysema
__ COPD
__ Bronchitis
__ Chronic Cough
__ TB (or family history of TB)
__ Shortness of Breath
__ Sleep Apnea
__ CPAP machine use
__ Home Oxygen, Liters _______
__ Other: ________________

Genital/Urinary:
__ Kidney Disease
__ Renal Failure
__ Dialysis
Last day received: __________
__ Incontinence
__ Other: ______________

Gastrointestinal:
__ Liver Disease
__ Jaundice
__ Hiatal Hernia
__ Reflux
__ Other: ______________

Blood and Coagulation:
__ AIDS/HIV
__ Hepatitis, Type: __________
__ Anemia
__ Bruising
__ Other: ______________

Nervous System:
__ Dementia, Alzheimer's
__ Stroke
__ Seizures/Epilepsy
__ Head/Neck Injury
__ Other: ______________

Endocrine:
__ Diabetes
__ Insulin
__ Thyroid Disease
__ Other: ________________

Musculoskeletal:
__ Chronic back/Neck problem
__ Arthritis
__ Multiple Sclerosis
__ Osteoporosis

Skin:
__ Rashes/Eczema/Hives
__ Open wounds/Sores/Lesions

Other:
__ Cataract RT ____ LT ____
__ Glaucoma RT ____ LT ____
__ Hearing loss: RT ____ LT ____
__ Cancer, Type: ______________
__ Recent cough/cold
__ Motion Sickness
__ Dentures
__ Anxiety/Depression

Have you taken any anticoagulant/blood thinner or aspirin in the last 3 months? YES______ NO ________
If YES, name of drug: ______________________ For what: ________________ Last dose: __________

Have you EVER taken the medication Flomax / Tamsulosin for prostate? YES______ NO ________
Do you use tobacco? YES _____ NO _____ Quit, When: ______________ Years of use: ____________
Do you drink alcohol? YES _____ NO _____ How many/week: ____________ Last drink: ____________
Lens Implant? YES _____ NO _____ Right _____ Left _____
Could you be pregnant? YES _____ NO _____ Last menstrual period: ____________________________
Arm Restrictions? YES _____ NO _____ ie: History of Dialysis Shunt or Mastectomy

ALL SURGICAL HISTORY: Procedures & Dates

____

____

ANESTHESIA REACTIONS: Have you had any complications related to anesthesia? YES _____, NO ________
Describe reaction: ____

______________________________________ Signature of Patient or Guardian Date

______________________________________ RN Signature Date

Form completed by: ________________________

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Updated with Patient Date: ____________ RN initial: _______

OUTPATIENT SURGICAL CARE, LTD

MEDICATION RECONCILIATION FORM

- **PLEASE LIST ALL ALLERGIES INCLUDING MEDICATION/FOOD/MATERIALS/ENVIRONMENT**

Allergy: ______________ Reaction: ______________ Allergy: ______________ Reaction: ______________

Allergy: ______________ Reaction: ______________ Allergy: ______________ Reaction: ______________

- **PLEASE LIST ALL MEDICATIONS, INCLUDING PRESCRIPTION AND NON-PRESCRIPTION**

Name of current medications:	**Dose:**	**Frequency:**	**Date last taken:**	**Reason for taking:**
		☐ Daily ☐ 2X a day ☐ As needed ☐ 3X a day ☐Bedtime ☐ OTHER:		
		☐ Daily ☐ 2X a day ☐ As needed ☐ 3X a day ☐Bedtime ☐ OTHER:		
		☐ Daily ☐ 2X a day ☐ As needed ☐ 3X a day ☐Bedtime ☐ OTHER:		
		☐ Daily ☐ 2X a day ☐ As needed ☐ 3X a day ☐Bedtime ☐ OTHER:		
		☐ Daily ☐ 2X a day ☐ As needed ☐ 3X a day ☐Bedtime ☐ OTHER:		
		☐ Daily ☐ 2X a day ☐ As needed ☐ 3X a day ☐Bedtime ☐ OTHER:		
		☐ Daily ☐ 2X a day ☐ As needed ☐ 3X a day ☐Bedtime ☐ OTHER:		
		☐ Daily ☐ 2X a day ☐ As needed ☐ 3X a day ☐Bedtime ☐ OTHER:		
		☐ Daily ☐ 2X a day ☐ As needed ☐ 3X a day ☐Bedtime ☐ OTHER:		

Form completed by ☐ Patient ☐ Other

Copy given to patient upon discharge:

Name: ______________________________ DOB: ____________ RN: ____________________ DOS: ____________________

Signature: ____________________________ Date: ____________ RN: ____________________ DOS: ____________________

FOR OFFICE USE ONLY:					
New medication added after surgery:	Dose:	Frequency	Route:	Reason for taking:	Today:
					☐ YES ☐ NO
					☐ YES ☐ NO