

Jefferson Ambulatory Surgery Center

2701 Lake Villa Drive Metairie, LA 70002 p: 504-274-3100 f: 504-274-3199

To Whom It May Concern:

Healthcare laws require that patients having a procedure performed in an outpatient facility are notified of their patient rights prior to the date of their procedure. Patient rights include patient notification of rights, responsibilities, filing a complaint, patient health privacy practices, and the knowledge of whether their physician has financial interest in the facility, in which the procedure is being performed.

Please review, sign, and bring the forms included in this packet with you on the day of your procedure. We also request that you bring in your insurance card (not needed if through worker's compensation) and a valid ID with name and picture on the day of your procedure.

Thank You,

Jefferson Ambulatory Surgery Center

JEFFERSON AMBULATORY SURGERY CENTER

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

SOCIAL SECURITY # _____ DRIVERS LICENSE _____

MAILING ADDRESS: _____

CITY/STATE/ZIP: _____

HOME #: () _____ WORK #: () _____ CELL #: () _____

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

CITY/STATE/ZIP: _____

NEAREST RELATIVE OR EMERGENCY CONTACT PERSON

NAME: _____ PHONE: () _____

ADDRESS: _____ RELATIONSHIP TO PT: _____

PRIMARY INSURANCE

INSURANCE COMPANY: _____

POLICY#: _____ GROUP#: _____

SUBSCRIBER'S NAME: _____ DATE OF BIRTH: ____/____/____

SOCIAL SECURITY #: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S EMPLOYER: _____ OCCUPATION: _____

IF ACCIDENT OR INJURY RELATED - DATE OF INJURY OR ONSET: _____

IF WORK RELATED - EMPLOYER NAME: _____ PHONE #: _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

POLICY#: _____ GROUP#: _____

SUBSCRIBER'S NAME: _____ DATE OF BIRTH: ____/____/____

SOCIAL SECURITY #: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S EMPLOYER: _____ OCCUPATION: _____

I HEREBY DECLARE THE INFORMATION PROVIDED BY ME IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____

Place Patient Label Here

DATE _____

JEFFERSON AMBULATORY SURGERY CENTER
Anesthesia Questionnaire – Please fill out completely

Patient name: _____ Today's date: _____

Surgeon: _____ Procedure date: _____

Procedure: _____ Sex: M or F

Height: _____ Weight: _____ # / _____ kg Age: _____

Vital Signs: B/P _____ Pulse _____ Resp _____ O2 sat _____ %

Food / Medication Allergies: _____

Have you ever had a reaction to any of the following? _____ If yes, please circle:
Tape Shellfish Iodine Betadine Latex Balloons Condoms Bananas Avocados Kiwi

Is your condition accident related? Yes or No Date of injury / MRI date: _____

Please list all surgical procedures you have had in the past: _____

Have you or any blood relative ever had an unusual reaction or problems with anesthesia?
Yes or No If yes, please describe: _____

Have you stopped taking any medications in preparation for this procedure? _____
If yes, list medicine and date stopped: _____

Did your surgeon want you to see your primary care doctor or a specialist to be cleared for this
procedure?

Yes or No If yes, name and number: _____

Have you had any recent lab work, or testing done? _____

Do you have: Dentures, Partials, Bridges, Plates, Caps, Crowns, or any loose or broken teeth?

Do you have contacts, piercings, any prosthetic devices / implants? _____

Have you been diagnosed with Sleep Apnea? _____

Do you use a Bi-pap or C-pap machine at night for Sleep Apnea? _____

Do you drink? _____ How often? _____

Do you smoke? _____ How much? _____

Any illegal drug usage? _____

Please answer the following yes/no questions and list medications used to treat any conditions in the space provided. Also, please note whether past or present:

	Yes	No	Medications	Notes
Cold in the last 2 weeks				
Chronic cough				
Asthma				
Emphysema				
Tuberculosis				
Shortness of breath				
Rheumatic fever				
Heart murmur				
Mitral valve prolapse				
High blood pressure				
Low blood pressure				
Chest pain / Angina				
Heart attack				
Irregular heart rate				
Palpitations				
Anemia				
Sickle cell trait / disease				
Jaundice				
Hepatitis / type				
Liver disease				
Disc disease				
Back / neck pain				
Hip / knee pain				
Sciatica				
Seizures / convulsions				
Epilepsy				
Stroke / paralysis				
Muscle weakness / cramps				
Polio				
Meningitis				
Thyroid problem				
Diabetes				
Hypoglycemia				
Kidney disease				
Kidney / bladder infection				
Hernia				
Hiatal hernia				
Reflux				
Ulcers				
Gastritis / colitis				
Diverticulosis				
Stomach / colon problems				

Please answer the following yes/no questions and list medications used to treat any conditions in the space provided. Also, please note whether past or present:

	Yes	No	Medications	Notes
Blood clot / Deep vein thrombosis				
Blood transfusion				
Free bleeder				
Migraines				
MRSA / Staph infection				
Fibromyalgia				
Lupus				
Multiple sclerosis				
Glaucoma				
Cancer - patient				
Cancer - family				
HIV / AIDS				
Venereal diseases				
Psychiatric problems				
Last menstrual period				
Pregnant				
Breast-feeding				
Any other medical conditions				

To the best of my knowledge, I have answered the above questions truthfully and completely:

Patient signature: _____ Date: _____

Surgeon's pre-op orders: _____ Anesthesia's pre-op orders: _____ pre-op as ordered _____
 no testing needed
 waive the following: _____

Anesthesia type: General MAC Spinal Ax Block Bier block
 Epidural Local ISB Other _____

Comments: _____

Anesthesiologist: _____ Date: _____

JEFFERSON AMBULATORY SURGERY CENTER

CONDITIONS OF SERVICE / PAYMENT

- I AUTHORIZATION AND CONSENT FOR TREATMENT:** I voluntarily authorize and consent to examinations, tests, procedures and medical treatment by employees and agents of Jefferson Ambulatory Surgery Center, physicians and their designees, as deemed advisable in their professional judgment. I understand that risks may be associated with diagnosis and treatment, and acknowledge that no guarantees have been made to me regarding results of examinations or treatments. I hereby authorize the Facility to dispose of, at its convenience, any specimens, tissue, or parts taken from my body in accordance with customary medical practice.
- II PERSONAL SAFETY:** I am made aware that some patients are at heightened risk of suffering falls because of their physical or mental condition or medication. I am instructed and encouraged, and agree to call for assistance when needed and to keep the protective bedrails up as necessary to avoid falling.
- III RELATIONSHIP BETWEEN THE FACILITY AND THE PHYSICIANS:** All physicians furnishing services to the patient, including radiologists, pathologists, and anesthesiologists, are independent contractors with the patient and are not employees or agents of the Facility. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the Facility and its nursing staff to carry out the instructions of such physician. Charges for services by physicians are not included in the Facility bill, but are billed separately by or on behalf of the physicians.
- IV FINANCIAL OBLIGATIONS:** The undersigned patient and / or the guarantor hereby individually obligate himself or herself to pay the charges of the Facility in accordance with its regular rates within (30) thirty days of balance billing. If you are actively enrolled as a member of a group that is contracted with your provider of services, then the terms and conditions of the agreement between your provider and your group will supersede this billing policy. Upon request, we will mail an itemized bill detailing by category the services you received. However, if the patient is eligible to receive insurance or health plan benefits, the patient shall not be obligated to pay for services to the extent paid for pursuant to the insurance plan, but shall be responsible for any unpaid balance due. All delinquent accounts shall bear interest at the rate of one (1%) per month from the date payment is due.
- V ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO FACILITY AND FACILITY BASED PHYSICIANS:** I hereby assign and authorize direct payment of any insurance or health plan benefits otherwise payable to or on behalf of the patient for these outpatient services (1) to the Facility for charges at a rate not to exceed the Facility's regular charges, and (2) to the physicians who are Facility based or for whom the Facility bills for their professional services at a rate not to exceed such physicians regular charges. This assignment includes any attorney's fees, costs, and penalties payable by the insurance company for late payment of the benefits assigned. In accordance with Louisiana law (LA R.S.22:67) payment pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations during this visit, the undersigned hereby authorize the application of such excess funds toward any other outstanding account(s) which the patient may have for any prior services rendered or for which the undersigned is responsible. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.
- VI AUTHORIZATION TO RELEASE INFORMATION:** I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse and HIV status, if applicable) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare, Medicaid, the insurance company, health maintenance organization, workers compensation insurance, person acting on behalf of a preferred provider arrangement or any other named third party, when such information is requested for payment, workers compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing.
- VII MEDICARE PATIENTS ONLY STATEMENTS TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER AND PHYSICIAN :** I request that payment of all Medicare benefits be made on my behalf to the Facility for any services furnished to me by the Facility and for any physician services billed by the Facility, as well as radiologist and/or pathologist for their services. I authorize any holder of medical or other information about me to release to Jefferson Ambulatory Surgery Center and its agents any information needed to determine these benefits for related services.
- VIII DISCLOSURE OF FINANCIAL INTERESTS:** Pursuant to Louisiana Law, please note that certain Physicians may have a financial interest in Jefferson Ambulatory Surgery Center. If you are referred to this facility and have any questions, please discuss this with your physician directly.
- VIII CERTIFICATION:** I certify that I have read this entire form, have had the opportunity to ask questions about it, have had them answered, and understand its contents. I certify that the information given to the facility is true, correct, and complete to the best of my knowledge.

Patient's Signature

Date

Jefferson Ambulatory Surgery Center

Patient Notification

PATIENT RIGHTS:

At Jefferson Ambulatory Surgery Center (JASC) the patient has the right to:

- Be informed of his/her rights in advance of, receiving care. The patient may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex, cultural, economic, education, religious background, physical handicap, or the source of payment for care.
- Considerate, respectful and dignified care, provided in a safe environment, with protection of privacy, free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Know of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see them. The patient has a right to request a change in providers if other qualified providers are available.
- Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes), and prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Receive a copy of a clear and understandable itemized bill and receive an explanation of his/her bill regardless of source of payment.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- The patient has the right to be advised as to the reason for the presence of any individual involved in his /her health care.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility.
- In the case of pediatric patients, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.
- The patient's written permission will be obtained before medical records can be made available to anyone not directly concerned with their care.

- Access information contained in his/her medical record within a reasonable time frame.
- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Be informed by his/her physician or a delegate, thereof, of the continuing healthcare requirements following their discharge from the facility.
- Be informed if Medicare eligible, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly.
- Receive upon request, prior to treatment, a reasonable estimate of charges for medical care.

PATIENT RESPONSIBILITIES:

- It is the patient's responsibility to read and understand all permits and / or consents to be signed: ask for clarification of any information not understood about your care or services.
- It is the patient's responsibility to answer all medical questions truthfully, including complete information about symptoms, past illnesses, medications, and other matters relating to care plan.
- It is the patient's responsibility to notify the ASC on admission if pre-operative instructions have not been followed.
- It is the patient's responsibility to provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours unless exempted from that requirement by the attending physician.
- It is the patient's responsibility to follow all post-operative instructions.
- It is the patient's responsibility to assure all payments for services rendered are on a timely basis, regardless of insurance coverage.
- It is the patient's responsibility to provide accurate financial and / or insurance information.
- It is the patient's responsibility to notify the Administrator of the ASC if the patient or the patient's representative thinks his rights have been violated.
- It is the patient's responsibility to respect the rights of other patients and ASC personnel.
- It is the patient's responsibility to inform the facility about the patient's Advance Directive.
- It is the patient's responsibility to follow the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.

ADVANCE DIRECTIVE NOTIFICATION:

In the state of Louisiana, all patients have the right to participate in their own health care decisions and to make Advanced Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient’s expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Jefferson Ambulatory Surgery Center respects and upholds those rights. However, unlike in an acute care hospital setting, the Surgery Center does not routinely perform “high risk” procedures. Most procedures performed in this facility are considered to be minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks. Your expected recovery, and care after surgery.

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

If you wish to complete an advance Directive, copies of the official state forms are available at our facility or you may obtain a copy via the state’s website:

<http://www.caringinfo.org/UserFiles/File/Louisiana.pdf>

If you do not agree with this facility’s policy, we will be pleased to assist you in rescheduling your procedure.

If a patient is adjudged incompetent under the states laws, the rights of the patient are exercised by the person appointed and or the legal representative designated on the patient’s behalf. The center will accept a Court appointed Guardian, Dual Power of Attorney, or a Health Care Surrogate.

DISCLOSURE OF OWNERSHIP

I understand that JASC is owned by a number of local physicians, one of whom may be my doctor. These physicians have become owners of JASC as a result of their commitment to quality healthcare and service to their patients. I understand that as an alternative to receiving care at JASC, I may choose another facility for the services I presently require, but voluntarily elect to receive care at JASC.

- Physician does have financial interest in the facility.
- Physician does not have a financial interest in this facility

PATIENT COMPLAINT OR GRIEVANCE:

You have the right to a fair, fast and objective review of any complaint you have regarding your health care. Your complaint should be directed to Susan McPherson, Administrator, Jefferson Ambulatory Surgery Center, (504)274-3100. If you are not satisfied with the response of Jefferson Ambulatory Surgery Center, you may contact DHH as follows:

Patient complaints or grievances may be filed through the State of Louisiana at 1-866-280-7737or (225)342-2205, via their website:www.dhh.louisiana.gov/offices/?id=112 to download a complaint form, or by writing to the address below:

Department of Health and Hospitals
ASC Program Manager
P.O. Box 3767
Baton Rouge, Louisiana 70821-3767

Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman.

Visit the Ombudsman website at:
www.cms.hhs.gov/center/ombudsman

For additional information regarding patient rights, responsibilities, advance directives, or health/safety you may visit: www.safecarecampaign.org

I certify that I received this information prior to the date of my procedure.

Comments/Questions: _____

Patient Signature: _____

Date: _____

Witness: _____